Claims Unit

INDIANA HEALTH COVERAGE PROGRAMS

Data Entry Operating Procedures Manual

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Version 1.1	August 2000	Chapters 2 thru 14.	Updates to staffing responsibilities and various claim screens.	Karen Knox, Karen Girgis
Version 2.0	August 2001	Chapters 2, 3 thru 14	Third Quarter Updates	Karen Knox and Rebecca Siewert

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Section 1: Introduction

Overview

This manual provides information on the procedures for manual data entry of Medicaid claims. This manual is used for training employees and as a reference for claims entry problems or issues.

The purpose of this manual is to enable the reader to understand the manual processing of paper claims. The descriptions and explanations of the procedures and standards used in data entry make it an invaluable training tool and reference.

This manual is organized into sections. The first three sections provide general information about the data entry function and the roles and responsibilities of those involved. The remainder of the manual provides specific instructions for data entry of claims, divided by claim type.

Section 2: Viking Security Maintenance

Overview

The Data Entry Supervisor is responsible for maintaining the security access to the Viking system. This process begins when an employee is hired with the company. The supervisor completes a "*Viking Security Information"* data sheet on the employee. An example of this form is located at the end of this section. The data sheet contains the employees name, the date the security access was initiated, the employees Viking ID and password. Once this information is completed, the supervisor signs and dates the form and places it in the employee's personnel file. If the employee leaves the company, the security access sheet is pulled from the employee's file and their Viking security access is cancelled. This information is completed at the bottom of the access sheet, which includes the date of cancellation and signature of the supervisor. After cancellation, the data sheet is filed in the employee's personnel file.

Procedures

The following procedure is used to assign access to the Viking system:

- Indiana Supervisor Routines
- VCS – User File Maintenance
- Insert New User Record
- Assigns User ID
- Assigns Password
- Inputs Employee Name
- Assigns Access Level

The following procedure is used to cancel access to the Viking system:

- Indiana Supervisor Routines
- VCS – User File Maintenance
- Type in User's ID
- Record Correct
- Record Delete
- Confirm Delete

VIKING SECURITY INFORMATION

NAME: _____ **DATE:** _____

VIKING ID: _____

PASSWORD:

ASSIGNED BY: _____

SIGNATURE: _____

DATE: _____

Viking Security Cancellation:

DATE DELETED: _____ **BY:** _____

SIGNATURE: _____

Figure 2.1 – Viking Security Information Sheet

Section 3: Roles and Responsibilities

Overview

The Data Entry Unit is part of the Claims Department. The Data Entry Unit consists of a supervisor and designated lead operators to oversee the correct entry of all manually processed claim data into Indiana*AIM*. The data entry supervisor reports directly to the claims director.

EDS Staff

Data Entry Supervisor

The data entry supervisor has the following responsibilities:

- Maintain daily production and inventory logs
- Ensure compliance with Medicaid program regulations
- Communicate and ensure implementation of work changes
- Maintain Viking security access
- Assist in developing all desk-level manuals used in claims processing
- Monitor unit production to ensure compliance with claims payment standards
- Serve as back up to other Claims Department supervisors
- Work closely with the unit team leaders to ensure compliance with established production rates for data entry
- Maintain daily production and inventory logs
- Order supplies on a weekly basis

Data Entry Unit Team Leader

The data entry team leader has the following responsibilities:

- Verify batches received from the mailroom
- Screen batches received from the mailroom for duplicate batch numbers

- Distribute batches to data entry operators
- Maintain daily production and inventory logs
- Order supplies on a weekly basis
- Troubleshoot problems encountered by data entry operators during claims entry
- Prepare claims for outsourcing within the designated time frame
- Unpack outsourced claims upon receipt
- Figure production statistics for each employee and submit to supervisor daily
- Monitor attendance of employees and submit Attendance Notification sheets to supervisor daily
- Figure machine time for each employee and submit to supervisor daily

Data Entry Quality Control Analyst

- Troubleshoot problems encountered by data entry operators during claims entry
- Perform verification and quality control checks on completed batches
- Deliver completed batches to the Resolutions Unit to be stored for reference
- Compute quality control statistics weekly for each data entry operator in each respective unit
- Train all new employees
- Cross-train all employees on other claim types, as required
- Monitor Viking reports daily
- Balance the Bach Activation Log book daily
- Resolve batch errors daily
- Monitor and update training needs for the data entry operators
- Type meeting minutes and distribute
- Resume back-up responsibilities to the lead operator when appropriate

Data Entry Operator

The data entry operator has the following responsibilities:

- Examine each claim for completeness and accuracy
- Reach and maintain established goals for production and accuracy
- Type claim information from claims into the system
- Understand and use claims processing reference manuals

State Responsibilities

The Data Entry Unit may be impacted by procedural or policy changes in the claims processing subsystem or the Medicaid program in general. The State's responsibilities, as outlined in the Request for Proposal (RFP) and with respect to claims processing and the Data Entry Unit, include the following items:

- Approve all revisions to claim form content and format
- Approve all revisions to claims processing procedures
- Approve internal and external claims processing control mechanism procedures
- Approve all revisions to claims processing manuals

Section 4: General Claim Information

Overview

After all claims are batched, microfilmed, and activated by the mailroom staff, they are brought to the Data Entry Unit. The team leader from each of the two data entry teams verifies that all batches listed on the Batch Activation Logs that accompany the claim types are present and that there are no duplicate batches. The team leaders store the batches by claim type in the respective areas.

Under the direction of the data entry supervisor, the team leaders prioritize work and distribute batches to the data entry operators. The data entry operators type in batches of claims, record the batch names of the batches completed, and the time required to type each batch on the Daily Operator Production Statistics form. Throughout each day, the team leaders redistribute batches, as necessary, to ensure that production is adjusted to changing priorities. At two separate times during the day, the quality control analyst informs each operator to interrupt the batch being keyed to perform quality control check. Once the batch is processed and interrupted, the batch is submitted to the quality control analyst for a key verification quality control check. Once the quality control check is completed, the quality analyst places the batch on temporary storage shelves in the Resolutions Unit. The inventory control clerk files the batch for future reference.

Internal Control Number

Medicaid claims are identified, tracked, and controlled by a unique 13-digit internal control number (ICN) that is assigned to each claim. The ICN shows when EDS received the claim, the claim submission media used, and the type of claim. The following tables describe the ICN format.

Table 4.1 – ICN Format

Internal Control Number Format	
R R Y Y J J J B B B S S S	
Field	**Description**
R R	These two digits refer to region codes assigned to a particular type of claim. Region codes allow multiple use of the remaining ICN component ranges, thus allowing more flexibility for high-volume claim submission periods. Region codes are identified in Table 3.2 of this manual.
Y Y	These two digits refer to the calendar year when the claim was received. For example, all calendar year 1998 receipts would have 98 in this field.
J J J	These three digits refer to the Julian date the claim was received. Julian dates are days elapsed since January 1. There are 365 days in a year, 366 in leap year, so a claim received on March 17, 1998, receives a Julian date of 076, indicating the 76th day of 1998.
B B B	These three digits refer to the batch range of a particular claim. Different claim types have different batch ranges that help to identify, track, and control claim inputs. Batch codes are identified in Table 4.3 of this manual.
S S S	These three digits refer to the specific sequence number of a particular claim within a specific batch range. A paper claim batch contains a maximum of 100 individual claims. An electronic claim batch contains a maximum of 1,000 claims. The first paper claim in a batch is given number 00. The first electronic claim in a batch is given number 000. The last claim in a batch is numbered 99 for paper claims and 999 for electronic claims.

Table 4.2 – Region Codes

Region Code	Description
10	Paper
11	Paper with attachment(s)
12	Claim Correction Form (CCF)
20	Electronic
22	Shadow (encounter)
23	Medicare crossover claims submitted via Provider Electronic Solutions
25	Point of Service (POS)
29	Reversal POS
40	Conversion claim (IMMIS to Indiana*AIM*)
50	Adjustment (provider request) – may result in either additional payment or the establishment of an accounts receivable (A/R)
51	Adjustment (check related) – an accounts receivable has been set up. This adjustment could also be the result of a surveillance and utilization review (SUR) audit.
55	Adjustment – resulting from a retroactive change in *per diem* rate for long term care facility
56	Adjustment (provider or OMPP request) to adjust a significant number of claims at one time due to a mass adjustment
60	Non-claim specific financial transaction
80	Claims previously denied in error and reprocessed by EDS
90	Special projects

Table 4.3 – Batch Ranges

Batch Range	Explanation
000-015	Crossover Part A/C
016-049	Crossover Part B
050-099	Dental
000-129	Inpatient
130-149	Outpatient
150-249	Long Term Care
250-299	Home Health
300-599	Pharmacy/Compound
600-899	Medical

Data Entry Screen Levels

Data entry screens are referred to as batch header, claim header, claim detail, and claim trailer screens. Crossover claims also have a crossover screen. In addition, there are numbers associated with each of these screens. These terms and numerical values replace the current record level terminology. The list below shows each type of data entry screen:

- Batch Header Form = 10
- Claim Header Form = 11
- Claim Detail Form = 21
- Claim Trailer Form = 31
- Claim Crossover Form = 41

Figure 4.4 displays an example of the Batch Header Form.

The crossover screens are shown in figure 4.5.

Indiana XIX Claims Entry Batch Header			
CT	ICN	REKEY	SEQ - END
	rryyjjjbbb	rryyjjjbbb	00 - __
NUM CLAIMS ___ DE CLERK			

Figure 4.1 – Batch Header Form 10

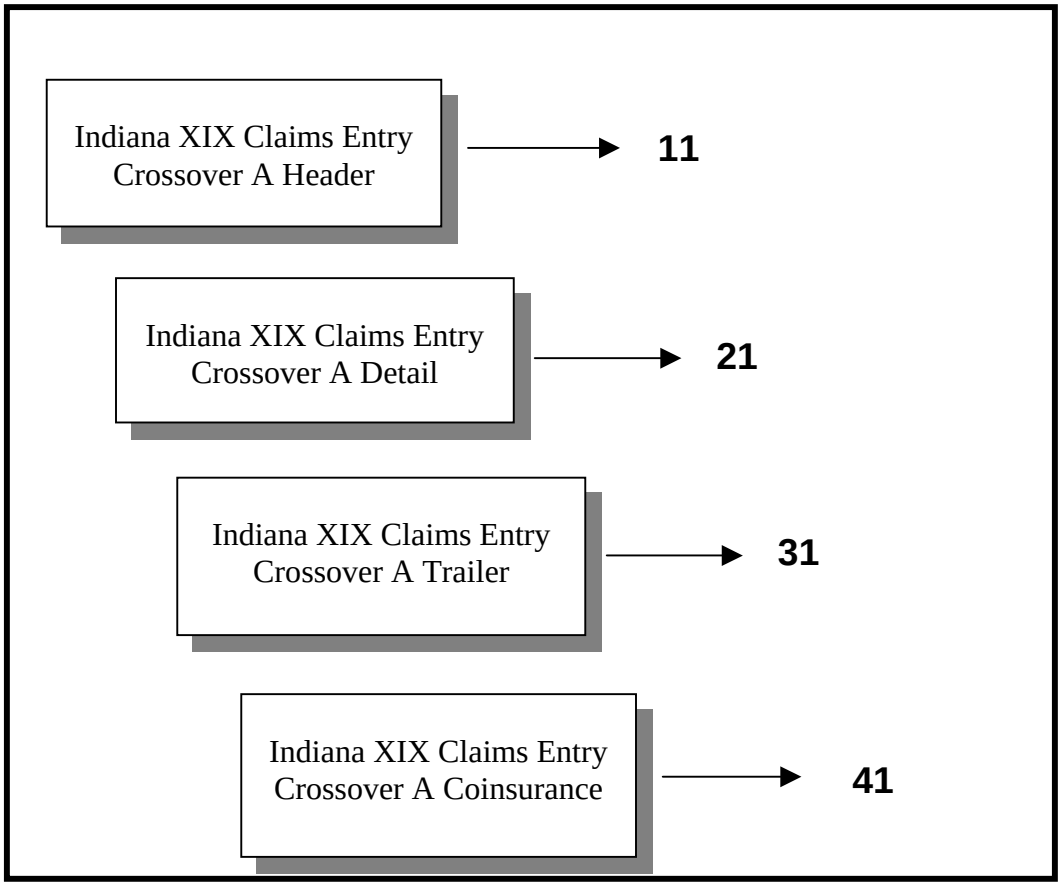


Figure 4.2 – Crossover Screens

Section 5: General Data Entry Information

Overview

The claims processing functional area accepts data in various formats and establishes control and tracking procedures for each claim type. Claims are submitted in electronic or hard copy format. Electronic claims are received in various formats, including tape-to-tape, diskette, point of sale for pharmacy claims, and personal computer transmissions using National Electronic Claims Submission (NECS) software.

This manual provides an overview of the Data Entry System. The data entry application runs on a dedicated Ultra 2000 server operating on a Unix platform. The data entry operators use Wyse terminals connected through a central data terminal server to DSIBSUN9. The Data Entry System supports 40 concurrent users. Completed batches are continuously captured, converted, and transferred to the claims engine for processing. Figure 5.1 shows how claims flow through Indiana Title XIX.

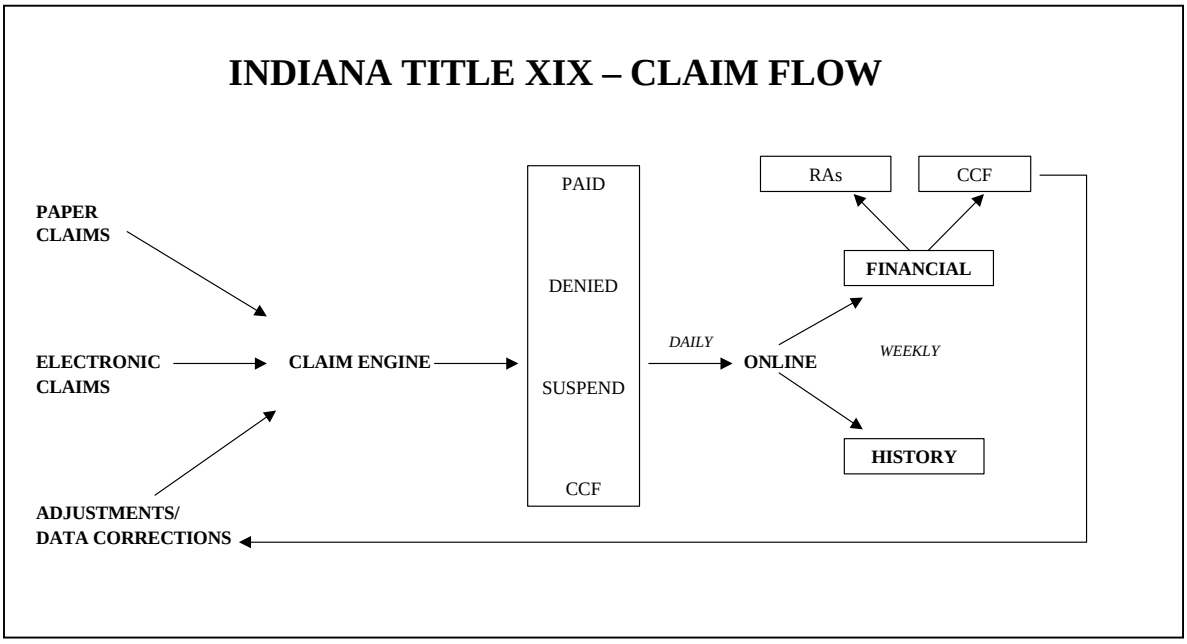


Figure 5.1 – Claim Flow Diagram

Data Entry System

The Data Entry System is a powerful application generator for fast-response, error-free keyboard input applications. The Data Entry System transforms the computer into an efficient workstation to type data rapidly and accurately, without additional hardware. It is frequently used to replace key-to-disk or keypunch machines. It is also used to create transaction files of data that are loaded into a database or used for processing by other programs.

Programming is not required to use the system. The necessary forms are created using the Forms Development Facility. Data entry does all the rest. Programmers can easily create customized versions using the optional product, Portal.

One of the features is a flexible security package that allows management to restrict entry, by operator, to specific functions. This ensures only authorized personnel are able to access the system and only for those jobs or functions they are authorized to use. Security for these features is established by completing a security screen for each operator.

Each data entry operator is assigned a four-digit identification number and a separate password. When an operator leaves the Data Entry Unit, the ID number assigned is deleted.

The data entry software performs range, value, cross-reference, and balancing edits for defined fields and has the ability to access selected extract (stub) files to verify provider, member, and reference information. These editing capabilities improve claims data entry accuracy, and reduce the number of claims suspending due to typographical errors.

Keyboard Function

The Data Entry System has special function keys. Special function keys provide the operator with cursor positioning and edit control abilities. Some of these functions are achieved by pressing a sequence of keys or by pressing keys simultaneously. A diagram of the keyboard configuration is located in Figure 5.2. The text describes each function key number and its purpose.

F3 – Menu Request

This function interrupts the job, stops the clock and displays a menu selection. The following menu is displayed:

```
A - Return to Current Record

B - Enter File Search Data

C - Continue Searching in the File

D - Quit and Delete Changes

E - Exit this File

F - File Balance

G - Sub-total Balance

H - Forms Change Selections

I - Interrupt this Job Step
```

When temporarily interrupting the job and returning the same day, use Type **A** to Return to the current record. When completing a batch, type **E** to Exit the File. When interrupting the job to complete the following morning, type **I** to interrupt the job.

F5 – Field Back

This function moves the cursor to the first position of each previous field.

F6 – Field Forward

This function moves the cursor to the first position of the next field.

F9 – Field Correct

This function allows the data entry operator to change or correct a field that is protected.

Shift/F8 – Reset Invalid Provider Number Edit

This function is required to clear the error edit message received after keying an invalid provider number. Once this message is cleared, the data entry operator must correct the provider number or location code. If the provider number and location code are keyed correctly and this

error message is received, the claim must be voided, pulled from the batch, and returned to the provider.

F10 – Record Correct

This function allows the data entry operator to change or correct an entire record that is protected.

F16 – Exit Scroll

This function allows the data entry operator to exit from the scrolling form on the detail screen once all detail lines are complete and move forward to the trailer screen.

REC INS – 10-Key Pad

This function allows the data entry operator to insert a record immediately in front of the current data record.

REC DEL – 10-Key Pad

This function allows the data entry operator to delete the current data record.

FRM CHG – 10-Key Pad

This function gives the user the ability to change forms. The following is a list of the form numbers:

- Batch Header Form = 10
- Claim Header Form = 11
- Claim Detail Form = 21
- Claim Trailer Form = 31
- X-over Form = 41

FLD DUP – 10-Key Pad

This function applies to the Claim Detail Screen only. The data from the previous detail line is copied from a Dup Buffer into the field being used and displayed on the screen. An error message is displayed if the field does not have a Dup Buffer assigned. Double verification fields do not have the Dup Buffer ability.

REC BACK – Up Arrow

This function allows the user to go back to previous fields.

REC FWD – Down Arrow

This function moves the cursor forward through each completed record to the last completed record.

CHAR BACK – Left Arrow Key

This function moves the cursor to the preceding position in the current field. When the cursor is already in the first position of the field, the request is ignored.

CHAR FWD – Right Arrow Key

This function moves the cursor forward in the current field, provided the current character is valid for that field. If the cursor was already on the last character of a field it is moved to the beginning of the next field.

Reset – Home Key

This function is required to clear an error message. Until the **HOME** or **ERR Reset** key is pressed, any other character is ignored, the bell rings and the error message displays.

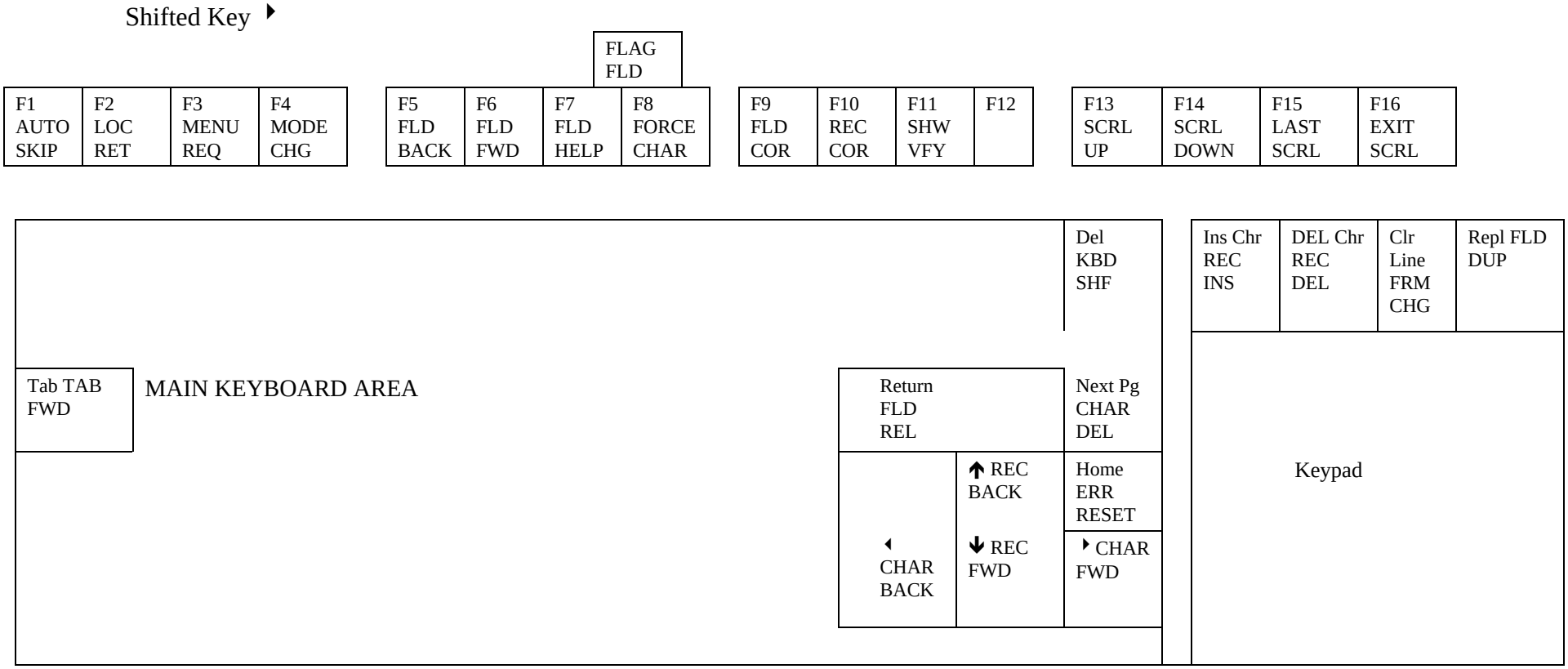


Figure 5.2 - Diagram of the Data Entry Keyboard

Getting Started

Prior to typing claims into the system there are several steps the data entry operator must complete. The following is a list of tasks and learning elements that are helpful to the data entry operator before beginning the claims entry process:

- Job/Select screen
- Universal Claim Batch Header
- Common fields of a claim
- Editing features of the system

Job/Select Screen

The data entry operator selects the job name for the claim type to be completed. The job name is selected by using the arrow keys to move the highlighted area to the appropriate job name. The job names for Indiana*AIM* claims are listed in Table 5.3.

Table 5.1 - System Job Names

Job Name	Claim Type
A	Institutional Crossovers
B	CMS/Medical Crossovers
C	Outpatient Crossovers
D	Dental
H	Home Health
I	Inpatient
L	LTC
M	CMS-1500/Medical
O	Outpatient
P	Pharmacy
Q	Compound Drug

After selecting the appropriate job name, press **Enter** or **Return**. At this time the operator is prompted with the following question, `Use 029 Keyboard?` The data entry operator is required to select **Y** for yes, or **N** for no. If the data entry operator is a straight 10-key

operator, **N** is selected. If the data entry operator is a reverse operator, **Y** is selected.

After selecting a keyboard option, the operator is taken to the batch name screen. The operator types in the batch name that consists of six bytes, in a JJJBBB format, where JJJ equals the Julian date of the batch and BBB equals the batch number of the batch. For claims jobs, this information is indicated on the batch header sheet attached to the outside of the batch folder and on microfilm stamped on each claim form.

Universal Claim Batch Header

```
                    Indiana XIX Claims Entry

                          Batch Header

CT         ICN              REKEY                  SEQ - END

           rryyjjjbbb       rryyjjjbbb              00 - __

NUM CLAIMS ____                    DE CLERK______
```

Figure 5.3 – Universal Claim Batch Header

ICN

Type the microfilmed ICN number stamped on the claim. When typing the ICN year, Viking performs an edit check to ensure it equals the current year or the current year minus one and flags the operator if the year does not match either of these. The operator must then correct the error to continue.

Rekey

Verify the ICN number by typing the number twice.

Ending Sequence Number

Type the sequence number of the last claim in the batch.

Common Fields on a Claim

Recipient

The member stub file consists of three fields for each record. The following list represents the name and number of characters for each recipient field:

- Member ID: 12 characters (1-12)
- Member Last Name: three characters (13-15)
- Member First Initial: one character (16)

Once the number is typed, it is verified against the member stub file. If a match is not found, the operator receives the following error message; `Entry is not in file`. The operator then verifies the number typed, and if the operator typed the RID number incorrectly the **Home** or **ERR Reset** key is pressed and the cursor moves to the beginning of the field. The operator must then retype the RID number from the claim. If the operator typed the RID number correctly **Home** or **ERR Reset** is pressed and the cursor moves to the beginning of the field. The operator must then press **FLD FWD** or **F6** to move the cursor to the next field.

Another type of editing performed using the member stub file is a member name to number match. Once the operator has typed the member's RID number and name, the stub file is checked to see if the name of the member matched the number typed. If a match is not found, the operator receives the error message; `Entry is not in file`. The operator then verifies the member's first and last name information. If the characters were typed incorrectly the operator presses **Home** or **ERR Reset** and the cursor moves to the beginning of the RID number. The operator must then press **FLD BACK** or **F5** until the cursor returns to the first or last name, depending on the field that needs corrected. If the operator typed the member's first and last name correctly the **Home** or **ERR Reset** key is pressed and the cursor moves to the beginning of the RID number. The operator must then press **FLD FWD** or **F6** to move the cursor to the next field.

Provider

The provider stub file contains two fields for each record on the file. Each record must contain nine numeric characters and one alpha character. The nine numeric characters represent the provider number and the alpha character represents the provider location.

Verification is done with the provider number field. The first time the operator types the provider number, the number typed is blanked out and the cursor automatically moves back to the first position in the field. The operator must then retype the provider number. If a different number is typed the second time, the operator receives the error message `Rekeyed Data Invalid`. The operator must press **Home** or **ERR Reset** to move the cursor to the beginning of the field. The operator must repeat the initial steps to type the provider number.

If the number typed the second time matches the original number, the provider ID number is verified against the provider stub file. If there is not a match found, the operator is prompted with the message, `Entry is not in file`. The operator verifies the number; if the number is incorrect the **Home** or **ERR Reset** key is pressed. The cursor moves to the beginning of the field and the data must be retyped. If the number typed is correct the **Home** or **ERR Reset** key is pressed. The operator must press the **FLD BACK** or **F5** key until the cursor is moved back to the void field on the screen. The operator must type **V** in the void field to void this claim. The claim is returned to the Claims Support Unit and returned to the provider.

Diagnosis

The diagnosis stub file contains the diagnoses on the diagnosis master file. Each diagnosis is from one to five characters in length. This stub file is accessed when the data entry operator keys the ICD-9 diagnosis code indicated on the claim form. The operator receives the error message; `Entry is not in file`, if the ICD-9 code typed does not match a number on the file. If a typing error was made in the diagnosis code, the operator must press **Home** or **ERR Reset**. The cursor moves back to the beginning of the field so the data must be retyped. If the diagnosis code was typed correctly, the operator must press **Home** or **ERR Reset**. The cursor moves back to the beginning of the field. The operator must then press **FLD FWD** or **F6** to move the cursor to the next field.

National Drug Code (NDC)

The NDC stub file contains all NDC codes on file. Each record is from one to 11 characters in length. The NDC typed by the operator is checked against the NDC stub file. If a match is not found, the operator receives the message; `Entry is not in file`. The operator verifies the information typed, and if an error was made, presses **Home** or **ERR Reset**. The cursor moves back to the beginning

of the field and the NDC must be retyped. If an error is not found, the operator presses **Home** or **ERR Reset**. The cursor moves back to the beginning of the field. The operator must press **FLD FWD** or **F6** to move the cursor to the next field.

Required Fields

The data entry operator follows the same procedures regardless of the stub file accessed. Once the procedure code is keyed and the appropriate file is accessed, if a match is not found, the operator is prompted with the message; `Entry is not in file`. The operator verifies the information typed, and if an error was made, presses **Home** or **ERR Reset**. The cursor moves back to the beginning of the field and the procedure code must be retyped. If an error is not found, the operator presses **Home** or **ERR Reset**. The cursor moves back to the beginning of the field. The operator must then press **FLD FWD** or **F6** to move the cursor to the next field.

Certain fields are required to contain valid data for the data entry process to continue. Examples of fields subjected to this type of editing are the provider number, provider location code, batch name, and the ICN on the batch header screen.

If invalid data is typed in the required field, the operator is flagged with the appropriate message at the top of the screen. Depending on the error, the operator may be required to exit the screen to correct a previous error. For example, if the batch name was incorrectly typed on the Batch Name screen, the operator is unable to type the correct ICN on the batch header screen. In order to correct, the operator must press the **arrow up** key to return to the previous screen. The operator must press **REC COR** or **F10** to correct the batch name. The operator must return to the batch header screen to type the correct ICN.

Edit Features

The system performs edits in addition to stub file edits. A brief description of the edits used in the Data Entry System is provided in the following text.

Numeric Field Checks

Certain fields must contain numeric values, for example, the ICN and date fields. These fields are programmed to accept only numeric values. If an operator attempts to type an alpha or special character,

the system does not accept the data and displays the message, `Illegal Character Keyed`. The operator must press **Home** or **ERR Reset**. The cursor returns to the first position in the field and the operator must type a numeric value.

Date Checks

Several types of edits are done on fields containing dates. Examples of date checks performed during the claims entry process are checking for a valid format or checking for a future date.

The majority of dates provided on claims are typed in the format MMDDYY. An edit is programmed to check for this format. If the operator types a date in a format other than MMDDYY, the operator is prompted with one of four messages:

- `Invalid month`
- `Invalid day`
- `This date after ICN date`
- `More than 1 yr. from ICN`

The operator verifies the information typed. If an error was made, the operator must press **Home** or **ERR Reset**, and the cursor returns to the invalid data. The operator must retype the data from the claim. If the information was typed correctly, the operator presses **Home** or **ERR Reset**. The operator must press **FLD FWD** or **F6** to forward to the next field.

Future date checks are done on the ICN field and on Date of Service fields. If an operator types a future date the operator receives the error message; `This date after ICN date`. For example, the ICN typed is 104165134, and the calendar date typed is May 10, 1998, (Julian date 130). The operator verifies the data typed. If data is typed incorrectly, the operator must press **Home** or **ERR Reset** and retype the correct data. The operator must press **FLD FWD** or **F6** to forward to the next field.

Total Charge Balancing

To assist in maintaining the integrity of claims information, an edit is programmed to check the charge information. For claims with multiple lines billed, the charges for each line are totaled and compared to the total charge typed by the operator. If the total charge typed does not

equal the sum of the line items, the operator is prompted with the message, `Dtl. charges NE Total`. The operator compares the data typed, both at the detail and total charge levels. The operator presses **Home** or **ERR Reset** and is prompted with the message, `Accept this Record,` select **Y** for yes, or **N** for no. If an error was made in typing the information, the operator types **N**. The cursor returns to the charge fields to allow correction. If an error was not made, the operator types **Y** and the data entry process continues with the trailer information of the claim.

Key Verification

Key verification requires the operator to type the same data twice to check for validity. If the operator fails to type the same data two times in succession, the operator is prompted with an appropriate message for the field data and must retype the data from the claim.

Key verification of data is required in the following fields:

- ICN
- Quantity
- Provider Number
- Units of Service

For certain fields, key verification is performed in conjunction with other types of edits such as stub file editing.

Section 6: CMS-1500 – Medical Claims

Overview

The CMS-1500 claim form is received from the provider for professional services rendered to a Medicaid member. The required information is typed on three screens with multiple data fields that supply information about the member and the treatment received. The following are data entry procedures for claims submitted on the CMS-1500 claim form. The instructions describe each field and reference each field number on the claim form.

Claim Header -Screen 1

```
                        Indiana XIX Claims Entry

                            CMS-1500/Medical

ICN ___________          SEQ NUM ___             VOID _

PROV NUM __________ _

LAST NAME ___            FIRST NAME _            RID _____________

ACC IND _                EDD _________           REFERRING PHYS __________

HOSP FROM _________      HOSP TO _________       RES LOC USE __

PDIAG _____              DIAG3 _____

DIAG2 _____              DIAG4 _____
```

Figure 6.1– CMS-1500/Medical Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Provider Number (Field 33)

This field indicates the unique 10-digit number assigned to the physician rendering service. This field requires nine numeric characters and one alpha character. The number always begins with

100 or 200. If the field is left blank, an invalid number is typed, or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Patient's Last Name (Field 2)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

Patient's First Name (Field 2)

This field represents the first name of the member. If a first name is not indicated on the claim, leave the field blank and force through the system. Type the first letter of the first name as indicated on the claim form.

Recipient Identification Number (RID #) (Field 1a)

This field represents the Medicaid identification number of the member. Type the number as indicated on the claim form. If the field is blank the RID number is sometimes in field 9a, field 10d, or field 11. If a valid number cannot be identified, type the number written in field 1a and force the claim through the system.

Accident Indicator (Field 10)

This field indicates whether treatment was rendered as a result of an accident. The required characters are **N** for no, **A**, **B**, or **C**. If the claim indicates that none of the boxes are marked or if the boxes are marked with **N**, press **Enter**, and the field systematically populates with an **N** for no. If a box is marked with yes, type the letter indicated. If two boxes are marked yes, type the first letter with the box indicated yes.

Expected Date of Delivery (EDD) (Field 14)

This date represents the expected date of delivery for a pregnant member. Type the date indicated on the claim form. This is not a required field. Leave the field blank if a date is not indicated.

Referring Physician (Field 17a)

This number represents the physician who referred the member for treatment. Type the physician's number indicated on the claim form. This is not a required field. Leave the field blank if the referring physician's number is not indicated on the claim form. If this field indicates an address or ZIP code, do not key. If there is any information other than the referring physician's number, do not key; leave the field blank.

Hospital From and To Dates of Service (Field 18)

The dates in this field represent the admission and discharge dates for the member. Type the information as indicated on the claim form. If the To Date of Service area is blank, the From Date of Service systematically populates by pressing **Enter**. If the From Date of Service area is blank, the To Date of Service systematically populates with the From Date of Service by pressing **Enter**. If the date is more than one year old, type the date as indicated on the claim form and force the claim through the system.

Reserved For Local Use (RES LOC USE) (Field 19)

Type the information as indicated on the claim form. This is not a required field. If there is no information on the claim form, leave the field blank. If any information other than two-digit alpha or numeric data is indicated, do not key; leave the field blank.

Diagnosis Codes (Field 21)

This field represents diagnosis codes for treatment provided to the member. Up to four codes may be typed in. If a code is invalid, type as written and force the claim through the system. If there is not a code

indicated on line 1, **FLD FRWD**, and leave blank. Codes must be typed as they appear on the claim form. In the example below codes must be typed from lines 1 and 3.

Example

1. code 3. code

2. 4.

Claim Details - Screen 2

Indiana XIX Claims Entry
CMS 1500/Medical Crossover

TOT CHG _____ TPL _____ NET CHG _____

Ln	From DOS	To DOS	POS	Proc	Modifiers 01 02 03	Diag	Detail Charge	Unit	F P	E M	Rendering Provider

****Repeat detail up to 6 times.

Figure 6.2– CMS-1500 Medical Crossover Claim Detail – Screen 2

Total Charge (Field 28)

This field represents the total of all charges submitted. Type charges as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Third Party Liability (TPL) (Field 29)

This field represents amounts due from other insurance carriers. Type amounts as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form leave the field blank.

Net Charge (Field 30)

This field represents the total charges, less any amount due from other insurance carriers. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The net charge is systematically balanced in Indiana*AIM*. If the system indicates the net charge is out of balance verify that the total charge and TPL amounts have been typed

correctly. If the amounts are correct and the net charge remains out of balance, type the amount indicated and force the claim through the system.

From and To Dates of Service (Field 24A)

Type the From Date of Service as indicated on the claim form. If the To Date of Service is the same, the field systematically populates with the From Date of Service by pressing **Enter**. If there is not a To Date of Service, leave the field blank and force through the system. If there is not a From Date of Service, but a To Date of Service is indicated, use the To Date of Service. If the date is older than one year, type the date as indicated on the claim form and force the claim through the system.

Place of Service (POS) (Field 24B)

This field represents the location where service was rendered. Type the place of service as indicated on the claim form. If the information is invalid or the field is blank, type the information as submitted and force the claim through the system. This is a two-digit field. If the information indicated on the claim form is a one-digit number, key a zero before the number.

Procedure Code (PROC) (Field 24D)

The procedure code identifies the services rendered to the Medicaid member. Type the procedure code as indicated on the claim form. If the information is invalid or the field is blank, type the information as submitted and force the claim through the system.

Modifiers (Field 24D)

There can be up to three modifiers indicated in this field to allow greater flexibility in billing for services rendered. Type modifiers as indicated on the claim form.

Diagnosis Code (Field 24E)

The diagnosis code indicates the reason for treatment. Type the diagnosis code as indicated on the claim form. If the code is invalid, type as submitted and force the claim through the system. If there is not a diagnosis code on the claim form, the field systematically populates to the default code of 1 when pressing **Enter**.

Detail Charge (Field 24F)

This field represents charges for services rendered. Type the charge as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is a $0.00 charge with a valid procedure code type the line detail as submitted.

Units (Field 24G)

This field indicates the number of units the provider is billing to Medicaid. Type the units as submitted on the claim form. This field requires verification; therefore type the number of units twice.

> *Note: When typing units do not use zeroes or fractions. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Family Plan (FP) (Field 24H)

This field indicates the member is pregnant. If the claim has **Y**, **X**, or **P** to indicate a pregnancy, type **Y** for Yes. If the field is blank or contains an N, indicating the member is not pregnant, type **N** for No. If the field is blank on the claim form or indicates **N**, the field populates to the default code **N**, for no, by pressing the **Enter** key.

Emergency (EM) (Field 24I)

This field indicates if treatment was provided as a result of an emergency. If the claim has **Y**, **X**, or **E** to indicate an emergency, type **Y**, for yes. If the field is blank or indicates the treatment was not an emergency, the field populates to the default code **N** for no, by pressing **Enter**.

Rendering Provider (Field 24K)

This field represents the physician who provided treatment. Type the provider number indicated on the claim form. If there is no provider number indicated, leave the field blank.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and correct or force the claim through the system. You must press the **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

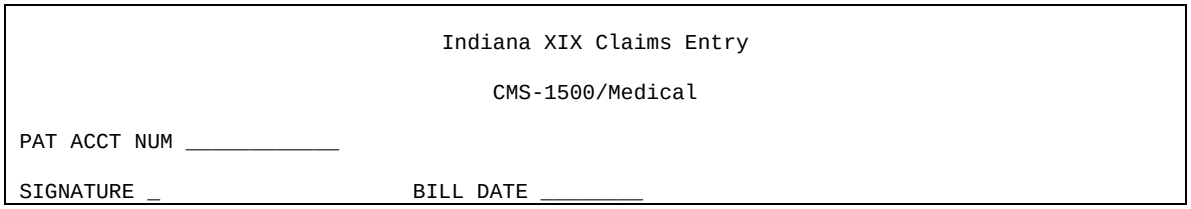


Figure 6.3 – CMS-1500/Medical Claim Trailer – Screen 3

Patient Account No. (Field 26)

This field represents an account number assigned to the member. Type the number indicated on the claim form. If there is not an account number provided, leave the field blank.

Signature (Field 31)

If the provider has signed the claim form, this field populates with the default code **Y**, or yes, by pressing **Enter**. If the provider has not signed the claim form, type **N**, for no.

Bill Date (Field 31)

Type the billing date that appears next to the signature. If there is not a date indicated, this field systematically populates with the date of the ICN by pressing **Enter**. If the date is over one year, type the date indicated and force the claim through the system.

Criteria for Voiding CMS-1500/Medical Claims

If a CMS-1500 medical claim form is missing any of the following information the claim cannot be processed and must be voided:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains more than six lines

Section 7: CMS-1500 – Medical Crossover Claims

Overview

Claims for services covered by Indiana Medicaid that have already been paid by Medicare are called crossover claims. Crossover claims are treated like any other third party liability (TPL) claim and paid up to the Medicaid maximum allowable. Medical crossover claims are processed like a regular medical claim with the exception of items detailed in the following data entry procedures.

Claim Header - Screen 1

```
                              Indiana XIX Claims Entry
                            CMS-1500/Medical Crossover


ICN ___________    SEQ NUM ____     VOID _____

PROV NUM __________ _

LAST NAME ___  FIRST NAME _   RID _____________

ACC IND _   EDD _________   REFERRING PHYS __________

HOSP FROM _________   HOSP TO _________  RES LOC USE __

PDIAG _____ DIAG3 _____

DIAG2 _____ DIAG4 _____
```

Figure 7.1 – CMS-1500 Medical Crossover Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Expectant Date of Delivery (EDD) (Field 14)

This field is not a required field for a crossover claim. The field is disregarded and no information is typed. If expectant date of delivery

information is included on the claim form the information is not typed in.

Hospital From and Hospital To Dates of Service (Field 18)

This field is not required for a crossover claim. The field is disregarded and no information is typed. If information is included on the claim form the information is not typed.

Reserved for Local Use (RES LOC USE) (Field 19)

This field is not required for a crossover claim. The field is disregarded and no information is typed. If information is included on the claim form the information is not typed.

Claim Detail – Screen 2

Indiana XIX Claims Entry
CMS-1500/Medical Crossover

TOT CHG _____ TPL _____ NET CHG _____

Ln	From DOS	To DOS	POS	Proc	Modifiers 01 02 03	Diag	Detail Charge	Unit	F P	E M	Rendering Provider

****Repeat detail up to 6 times.

Figure 7.2– CMS-1500 Medical Crossover Claim Detail – Screen 2

Claim Trailer - Screen 3

Indiana XIX Claims Entry
CMS-1500/Medical Crossover

PAT ACCT NUM _____ SIG IND _ BILL DATE _____

ALLOWED _____ DEDUCT _____ COINSUR _____ PROV PD _____ L/PR122 _____ TPL _____

Figure 7.3 – CMS-1500 Medical Crossover Claim Trailer – Screen 3

Allowed Amount

The allowed dollar amount is found on the Explanation of Medical Benefits (EOMB) attached to each claim. The amount usually matches the charge on the claim form and is identified as *Allowed, Submitted, or Covered Charges.* Type the amount as submitted on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Deductible Amount

The dollar amount of the deductible is found on the EOMB attached to each claim and is identified as *Deductible.* The amount must be typed as indicated on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always a deductible amount indicated.

Coinsurance Amount

The coinsurance dollar amount is found on the EOMB attached to each claim and is identified as *Coinsurance.* Type the amount as indicated on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always a coinsurance amount indicated.

Provider Paid Amount

The provider paid dollar amount is found on the EOMB attached to each claim. It is labeled on the EOMB as *Provider Paid* or *Net Reimbursement.* Type the dollar amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

L Amount/PR122 Amount

The L Amount or PR122 dollar amount is found on the EOMB attached to each claim. It is labeled on the EOMB as *L* or *PR122.* Type the dollar amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always an L or PR122 amount indicated.

Third Party Liability Amount

The TPL amount dollar amount is found on the TPL attachment with each claim. The TPL amount is from an insurance carrier or third party other than Medicare or Medicaid. This attachment indicates the amount a third party pays for the services rendered, if any. Type the dollar amount as indicated on the attachment. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always a TPL attachment indicated so a TPL amount is not always typed. After the TPL amount has been keyed, an edit flags the operator if an amount larger than the billed amount on the claim is entered. The operator must then check for errors, correct, or force the claim through Indiana*AIM*.

After keying all of the fields on this screen level, a balance check is performed. If an error message appears, the operator must verify the information typed in each field and correct any errors. If no errors are detected, the claim must be forced through Indiana*AIM*.

Criteria for Voiding CMS/Medical Crossover Claims

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any crossover claims. Crossover claims, from a provider not defined as an exception, cannot be processed and must be voided if missing any of the information listed below:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains more than six lines

In addition, the following criteria must be met before a Crossover claim is processed:

- A valid EOMB must be attached to each claim form
- The charges on claim form must also be listed on EOMB
- The charges on claim form must have an allowed amount listed on EOMB

Section 8: Dental Claims

Overview

The following are data entry procedures for claims submitted on the American Dental Association claim form. There are three screens and multiple data fields that supply information about the member and services rendered. The instructions describe each field, and reference each corresponding field number on the claim form.

Claim Header - Screen 1

```
                              Indiana XIX Claims Entry

                                   Dental Header
ICN ___________     SEQ NUM ___   VOID _
PROV NUM __________ _
LAST NAME ___       FIRST NAME _    RID _____________
ANOTHER PLAN? _
                    PLACE OF TREATMENT                                  OCC?_
OFFICE              HOSP.          ECF             OTHER                AUTO?_
_______             ______         ___             ______              OTHER?_
```

Figure 8.1 – Dental Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Provider Number

The dental provider number is a ten-digit number that consists of nine numeric characters and one alpha character and always begin with 100 or 200. This number identifies the dental provider who rendered service and must be a valid number. The dental provider number does not have a designated field on the dental claim form, so the entire claim form must be scanned. The dental provider number is generally written on the dental claim form between fields 16 and 19. This field requires verification; therefore the number must be typed twice.

If the field is left blank, an invalid number is typed, or a number is flagged invalid after typing, the claim must be voided and RTP.

Patient's Last Name (Field 1)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force the claim through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

Patient's First Name (Field 1)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name indicated on the claim, leave the field blank and force the claim through the system.

Recipient Identification Number (RID #) (Field 7 or 14b)

This field represents the Medicaid identification number assigned to the person seeking treatment. Type the number as submitted on the claim form. If this number is missing, invalid or flagged invalid after typing, verify the patient's first and last name, correct any typing errors, and force the claim through the system.

Another Plan (Field 11)

This field indicates coverage by another dental plan, and requires that **Y** for yes, or **N** for no, be typed. If the claim form indicates no, the patient is not covered by another dental plan, the field populates with the default code of **N** by pressing **Enter**. If the claim form indicates yes, the patient is covered by another dental plan, type **Y** for yes.

Place of Treatment (Field 22)

This field indicates the location where treatment was provided such as, office, hospital, extended care facility (ECF), or other. Type an **X** in

the field for the location indicated on the claim form. If the location is not indicated, leave the field blank.

Occ? Auto? Other? (Field 24-26)

This field indicates the circumstances that required the member to seek treatment. Type **Y** for yes in the field indicated on the claim form. The field populates with the default code **N** for no, by pressing **Enter**.

Claim Details - Screen 2

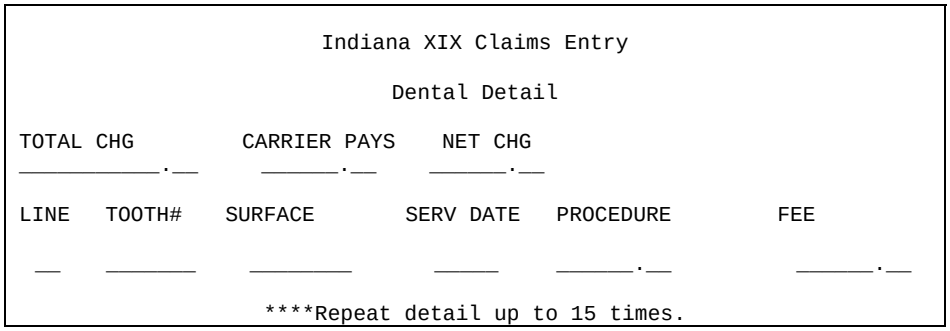


Figure 8.2 – Dental Claim Detail – Screen 2

Total Charge

This field, located at the bottom right side of the claim form, represents the total charge for services rendered. Type the charge as indicated on the claim form.

Carrier Pays

This amount represents an amount that is to be paid by another insurance carrier. It is located at the bottom right side of the claim form. Type the amount indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Net Charge

This amount represents the amount that is due from the member. This amount is located at the bottom right side of claim form. Type the charges indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If the system indicates the charges are out of balance, verify that the

Total Charge and Carrier Pay amounts have been typed correctly. If no errors are found, force the claim through the system. If the field is blank, type the amount indicated in the Total Fee Charged field.

Tooth # (Field 30/37, Item 1)

This field represents the number of the tooth being treated. Type the number indicated on the claim form. If the number is invalid or the field is blank, type as submitted or leave blank and force the claim through the system.

Surface (Field 30/37, Item 2)

This field represents the surface being treated on the tooth indicated above. Type the surface indicated on the claim form. If the information is invalid or the field is blank, type as submitted or leave blank and force the claim through the system.

Service Date (Field 30/37, Item 4)

The field represents the date service was rendered. Type the date as submitted on the claim form. If the date is greater than one year or missing, type as submitted or leave blank and force the claim through the system.

Procedure Code (Field 30/37, Item 5)

This field indicates the service provided to the member. This field requires a numerical code. Type the last four digits of the procedure code. The system populates a **D** in front of the procedure code. Codes 2050, 3210, 5154, and 5155 are exceptions to the above rule and a **Z** must be typed manually. When a **Z** code is typed, the system automatically flags the code and the claim must be forced through the system.

Fee (Field 30/37, Item 6)

This field represents the fees charged for the service provided. Type the charge submitted on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is a 0.00 charge with a valid procedure code, type the detail line as submitted.

> *Note: Depending on the type of American Dental Association Claim Form used, Field 30 may be labeled Field 37. This information is the same whether labeled Field 30 or Field 37. Also note that Item 3 is not included in this description because it is not typed into the system.*

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press **Exit Scrol**l or **F16** after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

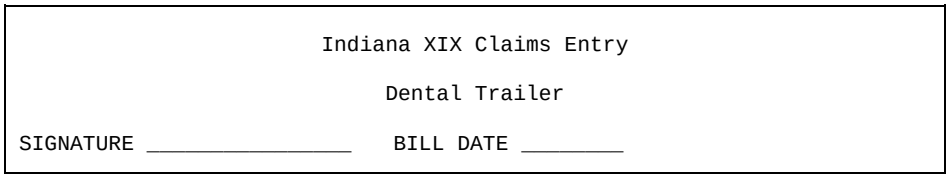


Figure 8.3 – Dental Claim Trailer – Screen 3

Signature

This field indicates the provider has signed the claim form. This field requires **Y** for yes, or **N** for no. The signature line is located at the bottom left hand of the claim form. If the provider signed the claim form the field populates with the default code **Y** for yes, by pressing **Enter**. If the provider has not signed the claim form, type **N** for no.

Bill Date

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature

line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing **Enter**. If the date is greater than one year, type the date as submitted and force the claim through the system.

Criteria for Voiding Dental Claims

A dental claim must be voided and cannot be processed for the following reasons:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains more than 15 lines

Section 9: Compound Drug Claims

Overview

Pharmacy providers use the Compound Drug Claim Form to submit charges for a prescription that combines more than one product or drug. The following narrative provides data entry procedures for claims submitted on the Compound Drug Claim Form. There are three screens and multiple data fields used to type information from the claim form. The instructions describe each field, and reference each field number on the claim form.

Claim Header - Screen 1

```
                              Indiana XIX Claims Entry

                                   COMPOUND DRUGS


ICN _____________       SEQ NUM ___      VOID
                                         __

PROV NUM __________ _

LAST NAME _____________   FIRST NAME __________   RID ________   PRESCRIB ID ___________

EMERG       PREG     NF        PAT                BRAND         REFILL

_____       _____    __        ___                _____         ______


PRESCRIPT   DATE                          DATE

NUMBER      PRESCRIBED               DISPENSED   QTY           DAYS         CHARGE   TPL PD

________    _________                _________   ____          ___          _______  ______
```

Figure 9.1 – Compound Drug Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Provider Number (Field 1-2)

This field indicates the unique number assigned to the provider rendering service. This 10-digit field requires nine numeric characters and one alpha character. The provider number begins with 100 or 200. If the field is left blank, an invalid number is typed or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Patient's Last Name (Field 3)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

Patient's First Name (Field 3)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name indicated on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #) (Field 4)

This field represents the member identification number assigned to the individual seeking treatment. Type the number as submitted on the claim form. If this number is missing, invalid, or flagged invalid after typing, type as submitted and force the claim through the system.

Prescriber ID Number (Field 5)

This field indicates the identification number of the provider prescribing the drug. Type what you see. If a prescriber identification number is not indicated, leave the field blank

Emergency (EMERG) (Field 6)

This field indicates if the prescription was dispensed in an emergency situation. If the claim has an **Y**, **X**, or **E** to indicate an emergency, type **Y** for yes. If the field is blank or indicates the treatment was not the result of an emergency, the field populates with the default code **N** for no, by pressing **Enter**.

Pregnant (PREG) (Field 7)

This field indicates the member is pregnant and requires **Y** for yes, or **N** for no. If the claim has **Y**, **X**, or **P** indicating pregnancy, type **Y** for yes. If the field is blank or indicates the member is not pregnant the field populates with the default code **N** for no, by pressing **Enter**.

Nursing Facility (NF Pat) (Field 8)

This field indicates if the patient is a nursing home resident and requires **Y** for yes, or **N** for no. If the claim has a **Y** indicating the member is a nursing resident, type **Y** for yes. If the field is blank or indicates no, the field populates with the default code **N** for no, by pressing **Enter**.

Brand (Box 9)

This is a numeric field that indicates if the drug prescribed is a brand name or generic drug. Type the information as indicated on the claim form. If the field is blank, indicates zero, or an alpha character, the field populates with zero by pressing **Enter**.

Refill (Field 10)

This field is a numeric field and indicates the number of refills prescribed. Type the information submitted on the claim form. If the field is blank, has a zero, or an **N**, the field populates with zero by pressing **Enter**.

Prescription Number (Field 11)

This field represents an identification number assigned by the dispensing provider. Type the number as indicated on the claim form. If a prescription number is not indicated, leave the field blank.

Date Prescribed (Field 12)

This field represents the date the drug was prescribed by the attending physician. Type the number as indicated on the claim form. If the date is greater than one year old, type the date and force the claim through the system.

Date Dispensed (Field 13)

This date represents the date the drug was dispensed to the member. Type the information as indicated on the claim form. If the prescribed date and dispensed date are the same, the prescribed date populates by pressing **Enter**. If the date is greater than one year old or missing, type as submitted and force the claim through the system.

Quantity (QTY) (Field 14)

This field represents the amount of the drug dispensed to the member. Type the amount as indicated on the claim form. If the quantity is indicates a fractional amount, round to nearest whole number. This field requires verification; therefore type the number twice.

> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Days (Field 15)

This field represents the number of days the drug is being supplied. Type the number of days indicated on the claim form. If the number of days is not indicated, the operator must press **Enter** and the system defaults to one.

Charge (Field 16)

This field represents the charge for the drug prescribed. Type the charges indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is a zero charge with a valid NDC number listed, the zero charge must be typed and the claim forced through the system.

Third Party Paid (TPL PD) (Field 17)

This field represents the dollar amount that is paid by another insurance carrier. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If a TPL amount is not indicated, leave the field blank.

Claim Details - Screen 2

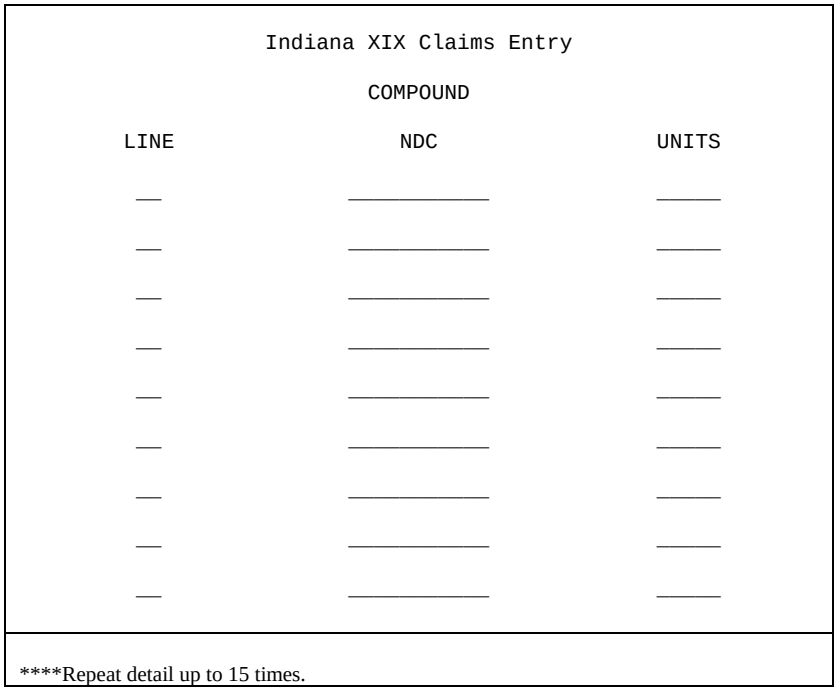


Figure 9.2 – Compound Drug Claim Detail – Screen 2

National Drug Code (NDC) (Field 21)

This field represents the unique code that identifies a specific drug. Each product in the compound has a different NDC. Type the information indicated on the claim form. If there is a quantity indicated without an NDC number, leave the field blank and force the claim through the system. If the NDC is flagged invalid after typed, force the claim through the system.

Units (Field 23)

The number in this field represents the number of units (ml, gm, or ea) to be reimbursed for the quantity dispensed. Type the information as

indicated on the claim form. This field requires verification; therefore type the number twice.

> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press **Exit Scroll** or **F16** to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

```
SIGNATURE ____     BILL DATE _____________
```

Figure 9.3 – Compound Drug Claim Trailer – Screen 3

Signature (Field 19)

This field indicates whether the provider has signed the claim form and requires **Y** for yes, or **N** for no. The signature line is located at the bottom left hand of the claim form. If the provider signed the claim form, the field populates with the default code **Y** for yes, by pressing **Enter**. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 20)

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by

pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Compound Drug Claims

A compound drug claim must be voided and cannot be processed for the following reasons:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains charges in excess of $9,999.99

Section 10: Pharmacy Claims

Overview

The following narrative describes data entry procedures for pharmacy claims submitted on the Pharmacy Claim Form. There are three screens and multiple data fields that supply information about the member and the treatment received. The instructions describe each field and reference each field number on the claim form.

Claim Header - Screen 1

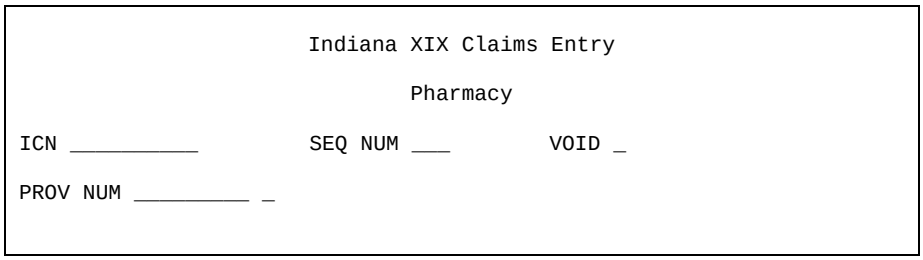


Figure 10.1 – Pharmacy Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICNs keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Provider Number (Field 01-02)

This field represents the 10-digit identification number assigned to the provider rendering service. This field requires nine numeric characters and one alpha character. The provider number begins with 100 or 200. If the field is left blank, an invalid number is typed or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Claim Detail - Screen 2

```
                                Indiana XIX Claims Entry

                                        Pharmacy

TOTAL CHARGES ____.__

DTL __   LAST NAME _________      FIRST NAME _________     RID _________    PRESCRIB ID__________

EMERG    PREG      NF        PAT   BRAND           REFILL

_____    ______    ___       ___   _____           _______

PRESCRIP     DATE                DATE

NUMBER       PRESC               DISP        NDC               QTY          DAYS

___________   ________________     _________    ________________    ___          ____

CHARGE    THIRD PARTY PAID
____.__   ____.__
```

****Repeat detail up to 10 times.

Figure 10.2 – Pharmacy Claim Detail – Screen 2

Total Charges (Field 03)

This field represents the total charge for the drug being dispensed. Type the charges as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Patient's Last Name (Field 04)

This field represents the last name of the member. Type the first three letters of the last name including special characters. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

Patient's First Name (Field 04)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name indicated on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #)

This field represents the member identification number assigned to the person seeking treatment. Type the number submitted on the claim form. If the number is missing, invalid, or flagged invalid after typing, correct any typing errors and force the claim through the system.

Prescriber's ID

This field indicates the identification number of the provider prescribing the drug. Type what you see. If a prescriber identification number is not indicated, leave the field blank.

Emergency (Field 07)

This field indicates if the prescription was provided in an emergency situation. If the claim has **Y**, **X**, or **E** to indicate an emergency, type **Y** for yes. If the field is blank or indicates the treatment was not an emergency, the field populates with the default code **N** for no by pressing **Enter**.

Pregnant (PREG) (Field 08)

This field indicates if the member is pregnant and requires **Y** for yes or **N** for no. If the claim has an **Y**, **X**, or **P** indicating pregnancy, type **Y**, for yes. If the field is blank or indicates the member is not pregnant the field populates with the default code **N** for no, by pressing **Enter**.

Nursing Facility Patient (NF PAT) (Field 09)

This field indicates if the patient is a nursing home resident and requires **Y** for yes, or **N** for no. If the claim has a **Y** indicating the member is a nursing resident, type **Y** for yes. If the field is blank or indicates no, the field populates with the default code **N** for no, by pressing **Enter**.

Brand (Field 10)

This is a numeric field that indicates if the drug prescribed is a brand name or generic drug. Type the information indicated on the claim form. If the field is blank, has a zero, or an alpha character, press **Enter** and the field populates with zero.

Refill (Field 11)

This is a numeric field that indicates the number of refills prescribed. Type the information submitted on the claim form. If the field is blank, has a zero, or an **N**, the field populates with zero by pressing **Enter**.

Prescription Number (Field 12)

This field represents an identification number assigned by the dispensing provider. Type the number indicated on the claim form. If a prescription number is not indicated, leave the field blank.

Date Prescribed (Field 13)

This field represents the date the drug was prescribed by the attending physician. Type the number indicated on the claim form. If the date is more than one year old, type the date and force through the system.

Date Dispensed (Field 14)

This date represents the date the drug was dispensed to the member. Type the information as indicated on the claim form. If the prescribed date and dispensed date are the same, the prescribed date populates by pressing **Enter**. If the date is more than one year old or is missing, type as submitted and force the claim through the system.

National Drug Code (Field 15)

This field represents the unique national drug code (NDC) that identifies a specific drug. Type the information as indicated on the claim form. If there is a quantity indicated without an NDC number, leave the NDC field blank and force through the system. If the NDC is flagged as invalid after it is typed, correct any typing errors and force the claim through the system.

Quantity (QTY) (Field 16)

This field represents the amount of the drug dispensed to the member. Type the amount indicated on the claim form. This field requires verification; therefore, type the quantity twice.

> *Note: When typing a quantity do not use fractions, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Days (Field 17)

This field represents the number of days the drug is being supplied. Type the date as indicated on the claim form. If the number of days is not indicated leave the field blank.

Charge (Field 18)

This field represents the charge for the drug prescribed. Type the charges indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is a zero charge with a valid NDC number listed, the zero charge must be typed and the claim forced through the system.

Third Party Paid (TPL Paid) (Field 19)

This field represents the dollar amount that is paid by another insurance company. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not a TPL amount indicated, leave the field blank.

*Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

```
                        Indiana XIX Claims Entry

                                Pharmacy

SIGNATURE ___________________    BILL DATE ________
```

Figure 10.3 – Pharmacy Claim Trailer – Screen 3

Signature (Field 21)

This field indicates whether the provider has signed the claim form and requires **Y** for yes, or **N** for no. The signature line is located at the bottom left side of the claim form. If the provider signed the claim form, the field populates with the default code **Y** for yes, by pressing **Enter**. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 22)

This field indicates the date the provider submitted the claim and is located at the bottom left side of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, the field populates with the ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Pharmacy Claims

A pharmacy claim must be voided and cannot be processed for the following reasons:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains charges in excess of $9,999.99

Section 11: Home Health Care Claims

Overview

The following narrative describes data entry procedures for home health care claims submitted on the UB-92 claim form. There are three screens and multiple data fields. The instructions describe each field and reference each field number on the claim form.

Claim Header - Screen 1

```
                                Indiana XIX Claims Entry

                                Home Health Claim Header

ICN _______________                    SEQ NUM _______       VOID __
PAT ACC # ____________          TOB _____              FROM DOS ____________        TO DOS ____________
CONDITION CODES              1 __    2 __    3 __    4 __    5 __    6 __    7 __    BOX 31 __

                        OC    DATE          OC    DATE       OC    DATE       OC        DATE
OCCURRENCE              __    ________      __    ________   __    ________   __        ________
CODES                   __    ________      __    ________   __    ________   __        ________
                        OC    FROM          THROUGH          OC    FROM       THROUGH
OCCURRENCE              __    ________      _________        __    ________   _________
SPAN                    __    ________      _________        __    ________   _________
                        VC    AMOUNT        VC          DATE       VC         DATE
VALUE                   __    _____.__      __          _____.__   __         _____.__
                        __    _____.__      __          _____.__   __         _____.__
CODES                   __    _____.__      __          _____.__   __         _____.__
                        __    _____.__      __          _____.__   __         _____.__
```

Figure 11.1 – Home Health Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Patient Account Number (Field 3)

This field represents the identification assigned to the member by the home health agency. Type the information submitted on the claim form. If there is not a patient account number indicated on the claim form, leave the field blank.

Type of Bill (TOB) (Field 4)

This field represents the type of bill being submitted by the home health agency. Type the information submitted on the claim form. A TOB is required and must be valid. If flagged invalid after typing, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

From Date of Service (Field 6)

This field represents the beginning date of service provided to the member. Type the date as indicated on the claim form. If the date is more than one year old, or there is not a date provided, type as submitted and force the claim through the system.

To Date of Service (Field 6)

This field represents the ending date of service provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service the system automatically populates by pressing **Enter**. If there is not a From Date of Service the system automatically skips to the next field. If there was not a From Date of Service but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Condition Codes (Field 24-30)

These fields represent conditions related to the services or treatments that may affect processing of the inpatient claim. Type codes as indicated on the claim form. If there are no codes indicated, leave the field blank. If the code is flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Unlabeled Field (Field 31)

This field represents the Hoosier Healthwise Primary Care Case Management (PCCM) primary medical provider (PMP) certification code. Type the information as submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Occurrence Codes and Dates (Field 32-35)

These fields represent significant events related to the services or treatments that may affect processing of the inpatient claim. Type the codes and dates submitted on the claim form. If there are no codes or dates indicated, leave the fields blank. If a code is flagged invalid after typing, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. If the date is more than one year old, type the date as submitted and force the claim through the system. If an occurrence code is not typed, the system automatically skips the date field. If there is a date, and an occurrence code is not indicated, manually go back to the date and type the date submitted on the claim form.

Occurrence Span (Codes and Dates) (Field 36)

This field represents the dates that each occurrence encompasses. Type the dates indicated on the claim form. If there are no codes or dates indicated, leave the field blank. If a code is flagged invalid after typing, correct any typing errors. If the code remains flagged invalid, force the claim through the system. If the date is more than one year old, type the date as submitted and force through the system. If the Through Date span is the same as the From Date span, the field populates by pressing **Enter**. If there is not a From Date indicated, the system automatically skips to the next field. If there is not a From Date indicated, but a Through Date has been submitted, manually go back to this field and type the date. If there is not an occurrence code, the system automatically skips to the next field. If there is a date indicated without an occurrence code, manually go back to the date field and type the date indicated on the claim form.

Value Codes and Amounts (Field 39-41)

These fields represent data elements necessary to process this claim. Type the value codes indicated on the claim form. If there are no codes indicated, leave the field blank. If a code is flagged invalid after typing, correct any typing errors. If there no typing errors are identified and the code remains flagged invalid, force the claim through the system. Type the amounts indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not a value code indicated, the system automatically skips the amount field. If there is an amount indicated without a value code, manually go back to the amount field and type the amount submitted on the claim form.

Claim Detail - Screen 2

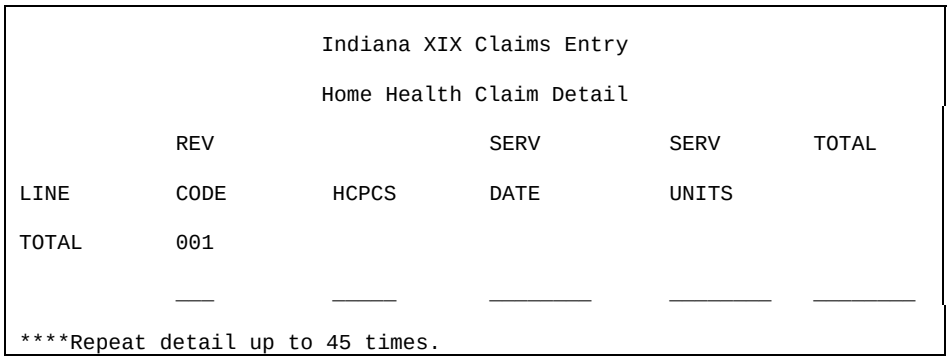


Figure 11.2– Home Health Claim Detail – Screen 2

Total Charge (Field 47)

This field represents the total charge of all detail lines. The total charge is obtained from the detail line with a REV code of 001. The REV code 001 is normally the last detail on the claim form.

REV Code (Field 42)

This field represents the specific accommodation, ancillary service or billing calculation. Type the information as indicated on the claim form. If missing, invalid, or flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

HCPCS (Field 44)

This field represents the Health Care Financing Procedure Coding System (HCPCS) code for treatment or service provided to the member. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code indicated is invalid or flagged invalid after typing, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. Do not type rates, or numbers with decimals in this field.

Service Date (Field 45)

This field represents the date service or treatment was provided to the member. Type the date as submitted on the claim form. If the date is missing, leave the field blank. If the date is more than one year old, type the date as submitted and force through the system.

Service Units (Field 46)

This field represents the number of service units billed in relation to the HCPCS code indicated on the claim form. Type the number of units indicated. If the field is blank, press **Enter** twice and the field populates with the default code of one. This field requires verification; therefore, type the units twice.

> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Total Charges (Field 47)

This field represents the total charge for all service units. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key down to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

```
                              Indiana XIX Claims Entry

                             Home Health Claim Trailer

PAYER    PROVIDER      PRIOR PAY   EST AMOUNT DUE

1  _   __________ _   _______.     _______.

2  _   __________ _   _______.     _______.

3  _   __________ _   _______.     _______.      DUE FROM PAT_______

LAST NAME ___   FIRST NAME _    RID _______

PRIN DIAG CD _____   OTHER DIAGS    ____  ____  ____  ____  ____  ____  ____  ____

                     E-CODE _____

                                                OTHER PROCEDURES

  PRINCIPLE      PROCEDURE          CODE   DATE    CODE    DATE   CODE   DATE

    CODE           DATE             ____   ____    ____    ____   ____   ____

    ____           ____             ____   ____    ____    ____   ____   ____

ATTENDING PHYS _____________________    OTHER PHYS.  A _______________     B _______________

SIGNATURE _______________     BILL DATE ________
```

Figure 11.3 – Home Health Claim Trailer – Screen 3

Payer (Field 50)

This field indicates the primary of the services for the member. Type the letter that represents the payer indicated on the claim form. This field allows one, two, or all three of the entries in the following list.

- A for Medicare
- B for other insurance
- C for Medicaid

Provider Number (Field 51)

This field represents the unique number assigned to the provider rendering service. This field requires 10 digits, nine numeric characters and one alpha character. The provider number always begins with 100 or 200. In this field the provider number is typed with Medicaid Payer. The system automatically skips over the provider number for payers A and B. If the field is left blank, an invalid number is typed or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice

Prior Payment (Box 54)

This field represents the amount that has been paid by any other carrier for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips this field if the payer is Medicaid. If there is an amount indicated, manually go back to the payer and type the amount indicated in the appropriate field.

Est. Amount Due (Field 55)

This field represents the amount due based on the HCPCS code used and the units of service. Type the information indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips this field if the Medicare or another insurance company is the payer. If there is an amount indicated manually go back to the appropriate field and type the amount indicated.

Due From Patient (Field 57)

This field represents the amount due from the member for non-covered items. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form leave the field blank. If there is an amount indicated in both the *Prior Payment* and *Estimate Amount Due* field, type the amount due in the *Estimate Amount Due* field.

Last Name (Field 58)

This field represents the last name of the member. Type the first three characters of the last name including special characters as indicated on the claim form. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

First Name (Field 58)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name indicated on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #) (Field 60)

This field represents the member identification number assigned to the person seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid, or flagged invalid after it is typed, correct any typing errors and/or force the claim through the system.

Principle Diagnosis Code (Prin Diag Cd) (Field 67)

This field represents the primary reason the member is receiving services or treatment. Type the information indicated on the claim form. If there is not a code indicated leave the field blank. If the code

is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Other Diagnosis Coded (Other Diags) (Field 68-75)

These fields represent the secondary reasons the member is receiving services or treatment. Type the information indicated on the claim form. If there are no secondary codes indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

E-Code (Box 77)

This field represents an emergency diagnosis code. Type the code submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Code (Field 80)

This field represents the primary service or treatment provided the member. Type the code indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after typing, type the code as submitted and force through the system.

Principle Procedure Date (Field 80)

This field represents the date the primary service or treatment was provided to the member. Type the date as indicated on the claim form. If there is not a date indicated, leave the field blank.

Other Procedure Code (Field 81)

This field represents secondary services or treatments provided to the member. This field allows up to five codes, type each code as submitted. If there are no secondary codes indicated, leave the field blank.

Other Procedure Date (Field 81)

This field represents the date the secondary services or treatments were provided to the member. Type the dates as indicated on the claim form. If there are no dates indicated, leave the field blank.

Attending Physicians Identification Number (Attending Phys. ID) (Field 82)

This field represents the license number of the physician who has primary responsibility for the member's medical care. In addition, this physician certifies the medical necessity for services or treatments provided to the member in the future. If there is not a license number indicated, leave the field blank.

Other Physician Identification Numbers (Other Phys. ID) (Field 83, Items A and B)

This field represents the license numbers of other physicians who have provided services or treatments to the member. Type the license numbers indicated on the claim form. The identification numbers must be typed in the order the services or treatments are submitted on the claim form. If there are no ID numbers indicated on the claim form, leave the field blank.

Signature (Field 85)

This field indicates whether the provider has signed the claim form. This field requires **Y** for yes, or **N** for no. The signature line is located at the bottom left hand of the claim form. If the claim was by the provider the field populates with the default code **Y** for yes when **Enter** is pressed. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 86)

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing Enter. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Home Health Care Claims

Home Health Care Claims must be voided and cannot be processed for the following reasons:

- Provider number is missing or invalid
- Location code is missing or invalid

- Detail contains more than 45 lines
- Type of bill missing or invalid

Section 12: Inpatient Claims

Overview

The following narrative describes data entry procedures for inpatient hospital claims submitted on the UB-92 claim form. There are three screens and multiple data fields. The instructions describe each field and reference each field number on the claim form.

Claim Header - Screen 1

```
                                Indiana XIX Claims Entry

                                    Inpatient Header

ICN__________                 SEQ NUM___                    VOID_

PAT ACC#_____________    TOB___          FROM DOS_________   TO DOS_________   COV DAYS  ___

ADMIT DATE ___________   ADMIT HOUR _____     ADMIT TYPE ____          PAT STAT__

CONDITION CODES     1__  2__  3__  4__  5__  6__   7__        BOX 31

                  OC       DATE       OC       DATE       OC       DATE      OC     DATE

   OCCURRENCE     __     ________     __     ________     __     ________    __    ______

      CODES       __     _________    __     _________    __     ________    __    ______

          VC  AMOUNT       VC  AMOUNT       VC  AMOUNT

 VALUE    __  _____.__     __  _____.__     __  _____.__

 CODES    __  _____.__     __  _____.__     __  _____.__
```

Figure 12.1 – Inpatient Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Patient Account Number (Field 3)

This field represents the account number assigned to the member by the inpatient facility. Type the information as submitted on the claim form. If there is not a patient account number indicated on the claim form, leave the field blank.

TOB (Type of Bill) (Field 4)

This field represents the type of bill being submitted by the inpatient facility. Type the information as submitted on the claim form. A TOB is required and must be valid. If flagged invalid after typing, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

From Date of Service (Field 6)

This field represents the beginning date of service provided to the member. Type the date indicated on the claim form. If the date is more than one year old, or there is not a date provided, type as submitted and force the claim through the system.

To Date of Service (Field 6)

This field represents the ending date of service that was provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service the system automatically populates when **Enter** is pressed. If there is not a From Date of Service, the system automatically skips to the next field. If there was not a From Date of Service, but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Covered Days (Field 7)

This field represents the number of days that are covered for the member for a specific course of treatment. Type the information as submitted on the claim form. If there are no covered days indicated, press **Enter** and leave the field blank.

Admission Date (Field 17)

This field represents the date the member was admitted to an inpatient facility. Type the date as indicated on the claim form. If there is not a date indicated, press **Enter** and leave the field blank. If the date is more than one year old, type the date as submitted and force the claim through the system.

Admission Hour (Field 18)

This field represents the time the member was admitted to an in-patient facility. Type the time indicated on the claim form. If there is not an hour given, press **Enter** and leave the field blank, the field automatically defaults to 99.

Admission Type (Field 19)

This field represents the priority of admission to an inpatient facility. Type the admission type as submitted on the claim form. If there is not an admission type indicated, press **Enter** and leave the field blank.

Status (STAT) (Field 22)

This field represents the status of the ending service for the period covered by the claim submitted. Type the status code indicated on the claim form. If there is not a status code indicated, press **Enter** and leave the field blank.

Condition Codes (Field 24-30)

These fields represent conditions related to the services or treatments that may affect processing of the inpatient claim. Type codes as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Unlabeled Field (Field 31)

This field represents the Hoosier Healthwise PCCM PMP certification code. Type the information as submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is flagged invalid after typing, correct any typing errors. If information has been

typed correctly and the code remains flagged invalid, force the claim through the system.

Occurrence Codes and Dates (Field 32-35)

These fields represent significant events related to the services or treatments that may affect processing of the inpatient claim. Type the codes and dates as submitted on the claim form. If there are no codes or dates indicated, leave the fields blank. If a code is flagged invalid after typing, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. If the date is more than one year old, type the date as submitted and force the claim through the system. If an occurrence code is not typed, the system automatically skips the date field. If there is a date and no occurrence code is indicated, manually go back to the date and type the date as submitted on the claim form.

Value Codes and Amounts (Field 39-41)

These fields represent data elements necessary to process this claim. Type the value codes indicated on the claim form. If there are no codes indicated, leave the field blank. If a code is flagged invalid after typing, correct any typing errors. If typing errors are not identified and the code remains flagged invalid, force the claim through the system. Type the amounts indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not a value code indicated, the system automatically skips the amount field. If there is an amount indicated without a value code, manually go back to the amount field and type the amount submitted on the claim form.

Claim Detail - Screen 2

```
                                Indiana XIX Claims Entry

                                    Inpatient Detail

LINE          REV          HCPCS          SERV          SERV          TOTAL

              CODE                        DATE          UNITS         CHARGES

TOTAL         001

__            ___          _____          ________      _______       _______.__

****Repeat detail up to 45 times.
```

Figure 12.2 – Inpatient Claim Detail – Screen 2

Total Charge (Field 47)

This field represents the total charge of all detail lines. This total charge is obtained from the detail line with a REV code of 001. The REV code 001 is normally the last detail on the claim form.

REV Code (Field 42)

This field represents the specific accommodation, ancillary service, or billing calculation. Type the information as indicated on the claim form. If missing, invalid, or flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

HCPCS (Field 44)

This field represents the HCPCS code for treatment or service provided to the member. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code indicated is invalid or flagged invalid after typing, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. Do not type rates or numbers with decimals in this field.

Service Date (Field 45)

This field represents the date service or treatment was provided to the member. Type the date as submitted on the claim form. If the date is missing, leave the field blank. If the date is more than one year old, type the date as submitted and force through the system.

Service Units (Field 46)

This field represents the number of service units billed in relation to the HCPCS code indicated on the claim form. Type the number of units indicated. If the field is blank, press **Enter** twice and the field populates with the default code of one. This field requires verification therefore the units must be typed twice.

> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Total Charges (Field 47)

This field represents the total charge for all service units. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press the **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

```
                                Indiana XIX Claims Entry

                                   Inpatient Trailer

PAYER          PROVIDER    PRIOR PAY        EST AMOUNT DUE

1       ___    __________  ______ _         ______.__

2       ___    __________  ______ _         ______.__

3       ___    __________  ______ _         ______.__   DUE FROM PT    _______.__

LAST NAME ___________   FIRST NAM _________   RID ____

PRIN DIAG CD _________  OTHER DIAGS _____  ______  _______  ______   ______   _____

ADM DIAG CD _____    E-CODE _____

OTHER PROCEDURES

PRINCIPLE PROCEDURE    CODE     DATE    CODE    DATE    CODE    DATE   CODE    DATE

                       _______  ______  ______  ______  ______  _____  ______  _____


ATTENDING PHYS _________________    OTHER PHYS A __________     B __________

SIGNATURE ______________________    BILL DATE _____________
```

Figure 12.3 – Inpatient Claim Trailer – Screen 3

Payer (Field 50)

This field indicates the primary payer of the services rendered to the member. Type the letter that represents the payer indicated on the claim form. This field allows one, two, or all three of the entries in the following list.

- A for Medicare
- B for other insurance
- C for Medicaid

Provider Number (Field 51)

This field represents the unique number assigned to the provider rendering service. This field requires 10 digits, nine numeric characters and one alpha character. The provider number always begins with 100 or 200. In this field the provider number is typed with Medicaid Payer. The system automatically skips over the provider number for payers A and B. If the field is left blank, an invalid number

is typed or a number is flagged invalid after it is typed, the claim must be voided and RTP. This field requires verification therefore the user is required to type the number twice.

Prior Payment (Box 54)

This field represents the amount that has been paid by any other carrier. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips the field if the payer is Medicaid. If there is an amount indicated, manually go back to the payer and type the amount in the appropriate field.

Est. Amount Due (Field 55)

This field represents the amount due based on the HCPCS code used and the units of service. The system automatically skips the field if the Medicare or another insurance company is the payer. If there is an amount indicated manually go back to the appropriate field and type the amount.

Due From Patient (Field 57)

This field represents the amount due from the member for non-covered items. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form leave the field blank. If there is an amount indicated in both the *Prior Payment* and *Estimate Amount Due* field, type the amount due in the *Estimate Amount Due* field.

Last Name (Field 58)

This field represents the last name of the member. Type the first three characters of the last name including special characters as indicated on the claim form. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O’Hara must be typed as O’H
- AL-Ismaeli must be typed as AL-

First Name (Field 58)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #) (Field 60)

This field represents the member identification number assigned to the person seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid, or flagged invalid after typing, correct any typing errors and/or force the claim through the system.

Principle Diagnosis Code (Prin Diag Cd) (Field 67)

This field represents the primary reason the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated leave the field blank. If the code is invalid or flagged invalid after typing, type the code as submitted and force the claim through the system.

Other Diagnosis Coded (Other Diags) (Field 68-75)

These fields represent the secondary reasons the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Admitting Diagnosis Code (ADM DIAG Code) (Field 76)

This field represents a diagnosis code that indicates the reason the member is receiving services or treatment. If there is not an admitting diagnosis code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

E-Code (Box 77)

This field represents an emergency diagnosis code. Type the code as submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Code (Field 80)

This field represents the primary service or treatment provided the member. Type the code as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Date (Field 80)

This field represents the date the primary service or treatment was provided to the member. Type the date as indicated on the claim form. If there is not a date indicated, leave the field blank.

Other Procedure Code (Field 81)

This field represents secondary services or treatments provided to the member. This field allows up to five codes, type each code as submitted. If there are no codes indicated, leave the field blank.

Other Procedure Date (Field 81)

This field represents the date the secondary services or treatments were provided to the member. Type the dates as indicated on the claim form. If there are no dates indicated, leave the field blank.

Attending Physicians Identification Number (Attending Phys. ID) (Field 82)

This field represents the license number of the physician who has primary responsibility for the medical care of the member. In addition, this physician certifies the medical necessity for services or treatments provided to the member in the future. If there is not a license number indicated, leave the field blank.

Other Physician Identification Numbers (Other Phys. ID) (Field 83, Items A and B)

This field represents the license numbers of other physicians who have provided services or treatments to the member. Type the license numbers as indicated on the claim form. The identification numbers must be typed to match the order the services or treatments are submitted on the claim form. If there are no ID numbers indicated on the claim form, leave the field blank.

Signature (Field 85)

This field indicates whether the provider has signed the claim form. This field requires Y for yes, or N for no. The signature line is located at the bottom left side of the claim form. If the claim was signed by the provider, the field populates with the default code Y for yes when **Enter** is pressed. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 86)

This field indicates the date the provider submitted the claim and is located at the bottom left side of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Inpatient Claims

Inpatient Hospital Claims must be voided and cannot be processed for the following reasons:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains more than 45 lines
- Type of bill missing or invalid

Section 13: Long Term Care/Nursing Home

Overview

The following narrative describes data entry procedures for long-term care facility and nursing home claims submitted on the UB-92 Claim Form. There are three screens and multiple data fields. The instructions describe each field and reference each field number on the claim form.

Claim Header - Screen 1

```
                              Indiana XIX Claims Entry

                                Long Term Care Header

ICN ___________   SEQ NUM ___        VOID _

PAT ACC # _________    TOB ___    FROM DOS _______    TO DOS _______   COV DAYS ___

ADMIT DATE _________   PAT STAT __

CONDITION CODES        1 __    2 __   3 __   4 __    5 __    6 __    7 __    BOX 31 __



             OC      DATE      OC     DATE       OC    DATE      OC    DATE

OCCURRENCE   __      ________  __     ________   __    ________  __    _______

CODES        __      ________  __     ________   __    ________  __    _______

             VC      AMOUNT      VC   DATE       VC    DATE

VALUE        __      _____.__    __   _____.__   __    _____.__

CODES        __      _____.__    __   _____.__   __    _____.__

             __      _____.__    __   _____.__   __    _____.__
```

Figure 13.1 – Long-Term Care Claim Header – Screen 1

Patient Account Number (Field 3)

This field represents the identification assigned to the member by the long-term care facility or nursing home. Type the information as submitted on the claim form. If there is not a patient account number indicated on the claim form, leave the field blank.

Type of Bill (TOB) (Field 4)

This field represents the type of bill being submitted by the long-term care facility or nursing home. Type the information as submitted on the claim form. A TOB is required and it must be valid. If flagged invalid after typing, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

From Date of Service (Field 6)

This field represents the beginning date of service provided to the member. Type the date as indicated on the claim form. If the date is more than one year old, or there is not a date provided, type as submitted and force the claim through the system.

To Date of Service (Field 6)

This field represents the ending date of service provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service the system automatically populates when **Enter** is pressed. If there is not a From Date of Service the system automatically skips to the next field. If there is not a From Date of Service but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Covered Days (Field 7)

This field represents the number of days that are covered for the member for a specific course of treatment. Type the information as submitted on the claim form. If there are no covered days indicated, press **Enter** and leave the field blank.

Admission Date (Field 17)

This field represents the date the member was admitted to the long-term care facility or nursing home. Type the date as indicated on the claim form. If there is not a date indicated, press **Enter** and leave the field blank. If the date is more than one year old, type the date as submitted and force the claim through the system.

Status (STAT) (Field 22)

This field represents the status of the ending service for the period covered by the claim submitted. Type the status code indicated on the claim form. If there is not a status code indicated, press **Enter** and leave the field blank.

Condition Codes (Field 24-30)

These fields represent conditions related to the services or treatments that may affect processing of the inpatient claim. Type codes as indicated on the claim form. If there are no codes indicated, leave the field blank. If the code is flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Unlabeled Field (Field 31)

This field represents the Hoosier Healthwise PCCM PMP certification code. Type the information as submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is flagged invalid after it is typed, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Occurrence Codes and Dates (Field 32-35)

These fields represent significant events related to the services or treatments that may affect processing of the inpatient claim. Type the codes and dates as submitted on the claim form. If there are no codes or dates indicated, leave the fields blank. If a code is flagged invalid after typing, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. If date is more than one year old, type the date as submitted and force the claim through the system. If an Occurrence Code is not typed, the system automatically skips the date field. If there is a date and an Occurrence Code is not indicated, manually go back to the date and type the date as submitted on the claim form.

Value Codes and Amounts (Field 39-41)

These fields represent data elements necessary to process the claim. Type the value codes indicated on the claim form. If there are no codes indicated, leave the field blank. If a code is flagged invalid after it is

typed, correct any typing errors. If no typing errors are identified and the code remains flagged invalid, force the claim through the system. Type the amounts indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not a value code indicated, the system automatically skips the amount field. If there is an amount indicated without a value code, manually go back to the amount field and type the amount submitted on the claim form.

Claim Detail - Screen 2

```
                              Indiana XIX Claims Entry

                                Long Term Care Detail

LINE              REV CODE          SERV DAT          SERV UNITS        TOTAL CHARGES

TOTAL             001

__                ___               _____             ________          _______.__

****Repeat detail up to 45 times.
```

Figure 13.2 – Long-Term Care Claim Detail – Screen 2

Total Charge (Field 47)

This field represents the total charge of all detail lines. The total charge is obtained from the detail line with a REV code of 001. The REV code 001 is normally the last detail on the claim form.

REV Code (Field 42)

This field represents the specific accommodation, ancillary service or billing calculation. Type the information as indicated on the claim form. If the information is missing, invalid, or flagged invalid after it is typed, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Service Date (Field 45)

This field represents the date service or treatment was provided to the member. Type the date submitted on the claim form. If the date is missing, leave the field blank. If the date is more than one year old, type the date as submitted and force through the system.

Service Units (Field 46)

This field represents the number of service units billed in relation to the HCPCS code indicated on the claim form. Type the number of units indicated rounded to the nearest whole number. If the field is blank, press **Enter** twice and the field populates with the default code of one. This field requires verification therefore the units must be typed twice.

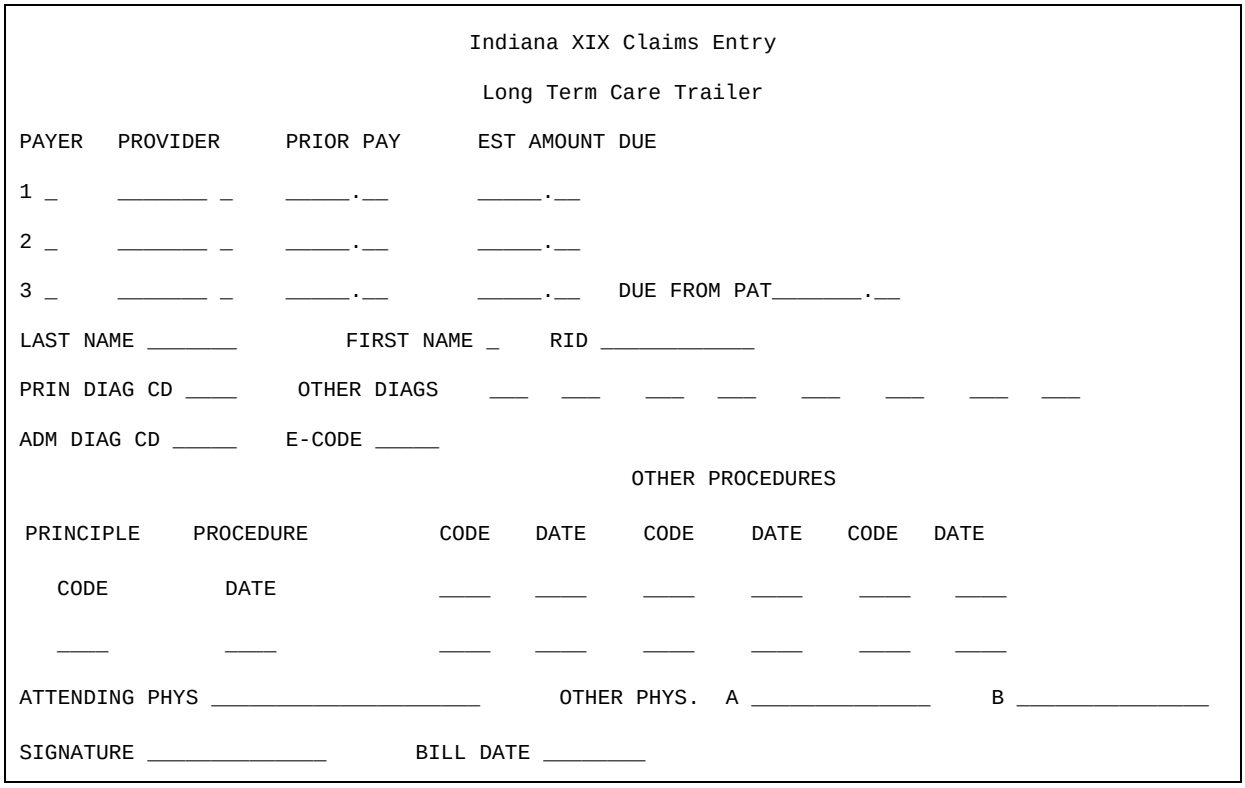
> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Total Charges (Field 47)

This field represents the total charge for all service units. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press the **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3



```
                                Indiana XIX Claims Entry

                                 Long Term Care Trailer

PAYER   PROVIDER     PRIOR PAY      EST AMOUNT DUE

1 _     _______ _    _____.__       _____.__

2 _     _______ _    _____.__       _____.__

3 _     _______ _    _____.__       _____.__   DUE FROM PAT_______.__

LAST NAME _______         FIRST NAME _    RID ____________

PRIN DIAG CD ____     OTHER DIAGS    ___   ___    ___   ___    ___    ___    ___   ___

ADM DIAG CD _____    E-CODE _____

                                                 OTHER PROCEDURES

 PRINCIPLE    PROCEDURE          CODE    DATE     CODE     DATE    CODE   DATE

    CODE         DATE             ____    ____     ____     ____    ____   ____

    ____         ____             ____    ____     ____     ____    ____   ____

ATTENDING PHYS _____________________      OTHER PHYS.  A _______________     B _______________

SIGNATURE _______________       BILL DATE ________
```

Figure 13.3 – Long-Term Care Claim Trailer – Screen 3

Payer (Field 50)

This field indicates the primary payer of the services rendered to the member. Type the letter that represents the payer indicated on the claim form. This field allows one, two, or all three of the entries in the following list.

- A for Medicare
- B for other insurance
- C for Medicaid

Provider Number (Field 51)

This field represents the unique number assigned to the provider rendering service. This field requires 10 digits, nine numeric characters and one alpha character. The number always begins with 100 or 200. In this field the provider number is typed with Medicaid Payer. The system automatically skips over the provider number for payers A and B. If the field is left blank, an invalid number is typed or

a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore, type the number twice.

Prior Payment (Box 54)

This field represents the amount that has been paid by any other carrier. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips this field if the payer is Medicaid. If there is an amount indicated, manually go back to the payer field and type the amount indicated in the appropriate field.

Estimated Amount Due (Est. Amount Due) (Field 55)

This field represents the amount due based on the services provided and the units of service. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips this field if the Medicare or another insurance company is the payer. If there is an amount indicated, manually go back to the appropriate field and type the amount indicated.

Due From Patient (Field 57)

This field represents the amount due from the member for non-covered items. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form leave the field blank. If there is an amount indicated in both the *Prior Payment* and *Estimate Amount Due* field, type the amount due in the *Estimate Amount Due* field.

Last Name (Field 58)

This field represents the last name of the member. Type the first three characters of the last name including special characters as indicated on the claim form. If there is not a last name indicated on the claim, leave the field blank and force the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O’Hara must be typed as O’H

- AL-Ismaeli must be typed as AL-

First Name (Field 58)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #) (Field 60)

This field represents the member identification number assigned to the person seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid or flagged invalid after it is typed, type the number as submitted and force the claim through the system.

Principle Diagnosis Code (PRIN DIAG CD) (Field 67)

This field represents the primary reason the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Other Diagnosis Coded (Other DIAGS) (Field 68-75)

These fields represent the secondary reasons the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Admitting Diagnosis Code (ADM DIAG Code) (Field 76)

This field represents a diagnosis code that indicates the reason the member is receiving services or treatment. If there is not an admitting diagnosis code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

E-Code (Box 77)

This field represents an emergency diagnosis code. Type the code as submitted on the claim form. If there is not a code indicated, leave the

field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Code (Field 80)

This field represents the primary service or treatment provided to the member. Type the code as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Date (Field 80)

This field represents the date the primary service or treatment was provided to the member. Type the date as indicated on the claim form. If there is not a date indicated, leave the field blank.

Other Procedure Code (Field 81)

This field represents secondary services or treatments provided to the member. This field allows up to five codes. Type each code as submitted. If there are no codes indicated, leave the field blank.

Other Procedure Date (Field 81)

This field represents the date the secondary services or treatments were provided to the member. Type the dates as indicated on the claim form. If there are no dates indicated, leave the field blank.

Attending Physicians Identification Number (Attending Phys. ID) (Field 82)

This field represents the license number of the physician who has primary responsibility for the medical care of the member. In addition, this physician certifies the medical necessity for services or treatments provided to the member in the future. If there is not a license number indicated, leave the field blank.

Other Physician Identification Numbers (Other Phys. ID) (Field 83, Items A and B)

This field represents the license numbers of other physicians who provided services or treatments to the member. Type the license numbers as indicated on the claim form. The identification numbers must be typed in the order the services or treatments are submitted on

the claim form. If there are no ID numbers indicated on the claim form, leave the field blank.

Signature (Field 85)

This field indicates whether the provider has signed the claim form and requires Y for yes, or N for no. The signature line is located at the bottom left hand of the claim form. If the provider signed the claim form, the field populates with the default code Y for yes by pressing **Enter**. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 86)

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Long-Term/Nursing Home Claims

Long-term care facility and nursing home claims must be voided and cannot be processed if missing any of the following information:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail containing more than 45 lines
- Type of bill missing or invalid

Section 14: Outpatient Claims

Overview

The following narrative describes data entry procedures for care received on an outpatient basis submitted on the UB-92 claim form. There are three screens with multiple data fields. The instructions describe each field and reference each field number on the claim form.

Claim Header - Screen 1

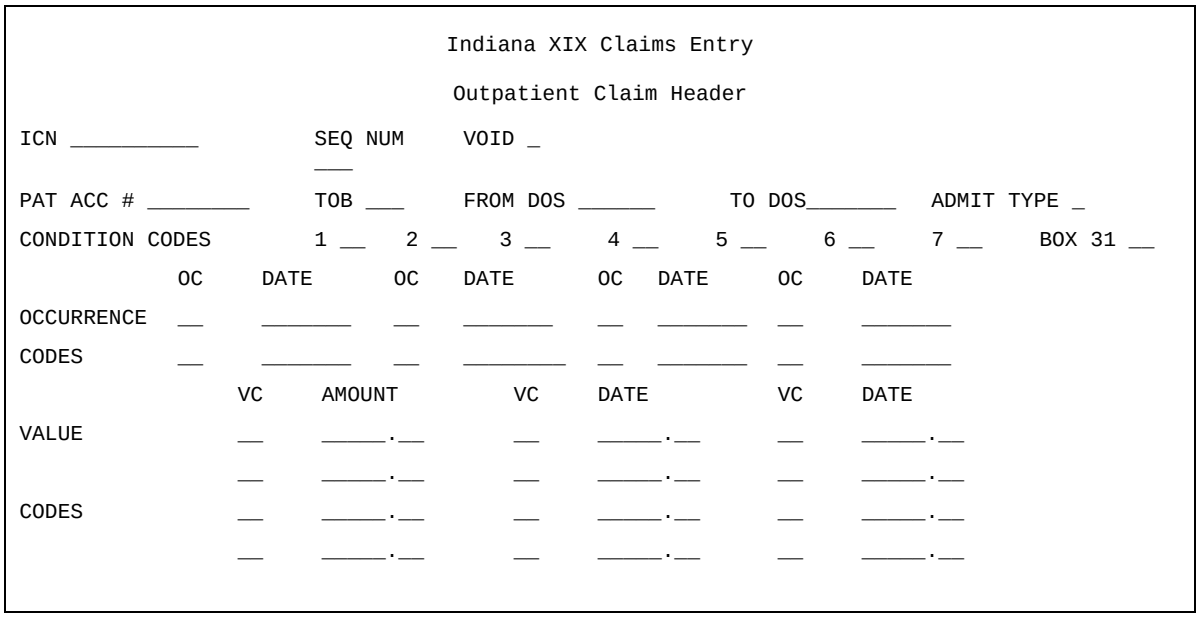


Figure 14.1 – Outpatient Claim Header – Screen 1

Patient Account Number (Field 3)

This field represents the identification number assigned to the member by the outpatient facility. Type the information as submitted on the claim form. If there is not a patient account number indicated on the claim form, leave the field blank.

Type of Bill (TOB) (Field 4)

This field represents the type of bill being submitted by the outpatient facility. Type the information as submitted on the claim form. A TOB is required and it must be valid. If the TOB is flagged invalid after it is

typed, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

From Date of Service (Field 6)

This field represents the beginning date of service provided to the member. Type the date as indicated on the claim form. If the date is more than one year old, or there is not a date provided, type as submitted and force the claim through the system.

To Date of Service (Field 6)

This field represents the ending date of service provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service, the system automatically populates when **Enter** is pressed. If there is not a From Date of Service, the system automatically skips to the next field. If there is not a From Date of Service, but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Admission Type (Field 19)

This field represents the priority of admission to the outpatient facility. Type the admission priority as submitted on the claim form. If there is not an admission type indicated, press **Enter** and leave the field blank.

Condition Codes (Field 24-30)

These fields represent conditions related to the services or treatments that may affect processing of the outpatient claim. Type codes as indicated on the claim form. If there are no codes indicated, leave the field blank. If the code is flagged invalid after it is typed, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Unlabeled Field (Field 31)

This field represents the Hoosier Healthwise PCCM PMP certification code. Type the information as submitted on the claim form. If there is not a code indicated, leave the field blank. If the code is flagged invalid after it is typed, correct any typing errors. If information has

been typed correctly and the code remains flagged invalid, force the claim through the system.

Occurrence Codes and Dates (Field 32-35)

These fields represent significant events related to the services or treatments that may affect processing of the outpatient claim. Type the codes and dates as submitted on the claim form. If there are no codes or dates indicated, leave the fields blank. If a code is flagged invalid after it is typed, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. If date is more than one year old, type the date as submitted and force the claim through the system. If there is not an Occurrence Code typed, the system automatically skips the date field. If there is a date and no Occurrence Code is indicated, manually go back to the date and type the date submitted on the claim form.

Value Codes and Amounts (Field 39-41)

These fields represent data elements necessary to process the claim. Type the value codes indicated on the claim form. If there are no codes indicated, leave the field blank. If a code is flagged invalid after it is typed, correct any typing errors. If no typing errors are identified and the code remains flagged invalid, force the claim through the system. Type the amounts indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not a value code indicated, the system automatically skips the amount field. If there is an amount indicated without a value code, manually go back to the amount field and type the amount submitted on the claim form.

Claim Detail - Screen 2

```
                                Indiana XIX Claims Entry

                                Outpatient Claim Detail

LINE            REV             HCPCS           SERV            SERV            TOTAL

                CODE                            DATE            UNITS           CHARGES

TOTAL           001

__              ___             _____           ________        _______         _______.__

****Repeat detail up to 45 times.
```

Figure 14.2 – Outpatient Claim Detail – Screen 2

Total Charge (Field 47)

This field represents the total charge of all detail lines. The total charge is obtained from the detail line with a REV code of 001. The REV code 001 is normally the last detail on the claim form.

REV Code (Field 42)

This field represents the specific accommodation, ancillary service, or billing calculation. Type the information as indicated on the claim form. If information is missing, invalid, or flagged invalid after it is typed, correct any typing errors. If information is typed correctly and the code remains flagged invalid, force the claim through the system.

(HCPCS) (Field 44)

This field represents the common procedure code or HCPCS code for the treatment or service provided to the member. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code indicated is invalid or flagged invalid after it is typed, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. Do not type rates or numbers with decimals in this field.

Service Date (Field 45)

This field represents the date service or treatment was provided to the member. Type the date as submitted on the claim form. If the date is missing, leave the field blank. If the date is more than one year old, type the date as submitted and force through the system.

Service Units (Field 46)

This field represents the number of service units billed in relation to the HCPCS code indicated on the claim form. Type the number of units indicated. If the field is blank, press **Enter** twice and the field populates with the default code of one. This field requires verification therefore type the units twice.

> *Note: When typing units do not use zeroes or fractions. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Total Charges (Field 47)

This field represents the total charge for all service units. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and either correct or force the claim through the system. You must press the **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer - Screen 3

```
                                Indiana XIX Claims Entry
                                Outpatient Claim Trailer
PAYER     PROVIDER            PRIOR PAY       EST AMOUNT
                                              DUE
1 _       _________ _         _______.__      _______.__
2 _       _________ _         _______.__      _______.__
3 _       _________ _         _______.__      _______.__      DUE FROM PAT_______.__
LAST NAME _____________   FIRST NAME _      RID _____________
PRIN DIAG CD ____   OTHER DIAGS ____   ____   ____    ____   ____    ____   ____   ____
ADM DIAG CODE ____    E-CODE _____
                                                OTHER PROCEDURES
 PRINCIPLE    PROCEDURE          CODE   DATE    CODE    DATE   CODE   DATE
   CODE         DATE             ____   ____    ____    ____   ____   ____
   ____         ____             ____   ____    ____    ____   ____   ____
ATTENDING PHYS _____________________      OTHER PHYS.  A _______________    B _______________
SIGNATURE _______________      BILL DATE ________
```

Figure 14.3 – Outpatient Claim Trailer – Screen 3

Payer (Field 50)

This field indicates the primary payer of the services rendered to the member. Type the letter that represents the payer indicated on the claim form. This field allows one, two, or all three of the entries in the following list.

- A for Medicare
- B for other insurance
- C for Medicaid

Provider Number (Field 51)

This field represents the unique number assigned to the provider rendering service. This field requires 10 digits, nine numeric characters and one alpha character. The number always begins with 100 or 200. In this field the provider number is typed with Medicaid payer. The system automatically skips over the provider number for payers A and B. If the field is left blank, an invalid number is typed, or a number is flagged invalid after it is typed, the claim must be voided

and RTP. This field requires verification therefore the user is required to type the number twice.

Prior Payment (Box 54)

This field represents the amount that has been paid by any other carrier for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The system automatically skips this field if the payer is Medicaid. If there is an amount indicated, manually go back to the payer and type the amount indicated in the appropriate field.

Est. Amount Due (Field 55)

This field represents the amount due based on the HCPCS code used and the units of service. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. This system automatically skips this field if the Medicare or another insurance company is the payer. If there is an amount indicated manually go back to the appropriate field and type the amount indicated.

Due From Patient (Field 57)

This field represents the amount due from the member for non-covered items. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form leave the field blank. If there is an amount indicated in both the *Prior Payment* and *Estimate Amount Due* field, type the amount due in the *Estimate Amount Due* field.

Last Name (Field 58)

This field represents the last name of the member. Type the first three characters of the last name including special characters as indicated on the claim form. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O’Hara must be typed as O’H

- AL-Ismaeli must be typed as AL-

First Name (Field 58)

This field represents the first name of the member. Type the first letter of the name submitted. If there is not a first name on the claim, leave the field blank and force through the system.

Recipient Identification Number (RID #) (Field 60)

This field represents the member identification number assigned to the person seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid or flagged invalid after typing, correct any typing errors and/or force the claim through the system.

Principle Diagnosis Code (PRIN DIAG CD) (Field 67)

This field represents the primary reason the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Other Diagnosis Coded (Other DIAGS) (Field 68-75)

These fields represent the secondary reasons the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Admitting Diagnosis Code (ADM DIAG Code) (Field 76)

This field represents the diagnosis indicating the reason the member is receiving services or treatment. If there is not an admitting diagnosis code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

E-Code (Box 77)

This field represents an emergency diagnosis code. Type the code as submitted on the claim form. If there is not a code indicated, leave the

field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Code (Field 80)

This field represents the primary service or treatment provided the member. Type the code indicated on the claim form. If there is not a code indicated, leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force through the system.

Principle Procedure Date (Field 80)

This field represents the date the primary service or treatment was provided to the member. Type the date as indicated on the claim form. If there is not a date indicated, leave the field blank.

Other Procedure Code (Field 81)

This field represents secondary services or treatments provided to the member. This field allows up to five codes. Type each code as submitted. If there are no codes indicated, leave the field blank.

Other Procedure Date (Field 81)

This field represents the date the secondary services or treatments were provided to the member. Type the dates as indicated on the claim form. If there are no dates indicated, leave the field blank.

Attending Physicians Identification Number (Attending Phys. ID) (Field 82)

This field represents the license number of the physician who has primary responsibility for the medical care of the member. In addition, this physician certifies the medical necessity for services or treatments provided to the member in the future. If there is not a license number indicated, leave the field blank.

Other Physician Identification Numbers (Other Phys. ID) (Field 83, Items A and B)

This field represents the license numbers of other physicians who have provided services or treatments to the member. Type the license numbers indicated on the claim form. The identification numbers must be typed to match the order the services or treatments are submitted on

the claim form. If there are no ID numbers indicated on the claim form, leave the field blank.

Signature (Field 85)

This field indicates whether the provider has signed the claim form and requires Y for yes, or N for no. The signature line is located at the bottom left hand of the claim form. If the provider signed the claim form, the field populates with the default code Y for yes when **Enter** is pressed. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 86)

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Criteria for Voiding Outpatient Claims

Outpatient hospital claims must be voided and cannot be processed if missing any of the following information:

- Provider number is missing or invalid
- Location code is missing or invalid
- Detail contains more than 45 lines
- Type of bill missing or invalid

Section 15: Outpatient Crossovers

Overview

Claims for services covered by Indiana Medicaid that have already been paid by Medicare are called crossover claims. Crossover claims are treated as any TPL claim and paid up to the Medicaid maximum allowable. Outpatient crossover claims are processed like regular outpatient claims with the exception of items detailed in the following procedures.

Claim Coinsurance - Screen 4

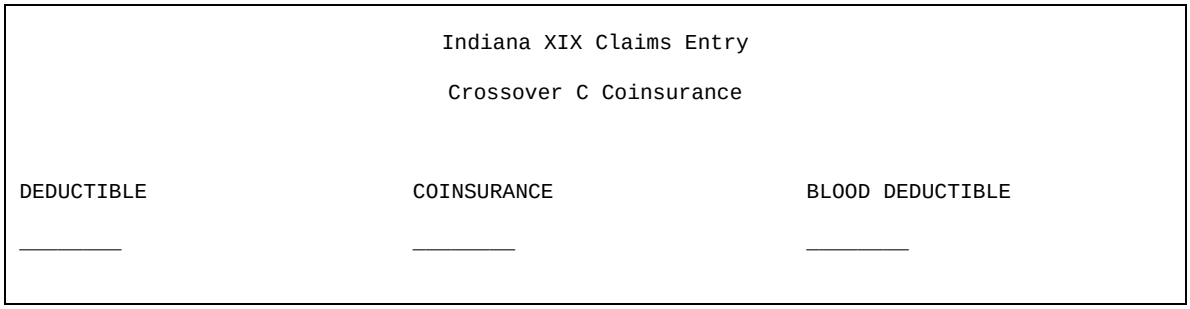


Figure 15.1 – Outpatient Crossover Claim Coinsurance – Screen 4

Deductible Amount

This is the dollar amount of the deductible found on the EOMB attached to each claim and is identified as *Deductible.* The amount must be typed as indicated on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always a deductible amount.

Coinsurance Amount

The dollar amount of Coinsurance is found on the EOMB attached to each claim and is identified as *Coinsurance.* Type the amount as indicated on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. There is not always a coinsurance amount.

Blood Deductible

The dollar amount of the blood deductible is found on the EOMB attached to each claim and is identified as *Blood Deductible.* Type the amount indicated on the EOMB. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Balance Check

After keying the deductible, coinsurance, and blood deductible, Viking performs a balance check and alerts the operator if anything larger than the total billed amount on the claim detail is entered.

Criteria for Voiding Outpatient Crossovers

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any outpatient crossover claims. In addition, the following criteria must be met before a crossover claim is processed:

- EOMB must be valid and attached to claim form
- Charges on claim form must also be listed on EOMB
- Deductible, coinsurance, or blood deductible amount must be listed on the EOMB

Section 16: Institutional Crossovers

Overview

Institutional crossover claims are processed in the same manner as regular inpatient claims with an additional screen to complete. The additional screen is identical to the outpatient crossover screen and is processed the same.

Criteria for Voiding Institutional Crossover Claims

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any outpatient crossover claims. In addition, the following criteria must be met before a crossover claim is processed:

- EOMB must be valid and attached to claim form
- Charges on claim form must also be listed on EOMB
- Deductible, coinsurance, or blood deductible amount must be listed on the EOMB

Section 17: Medical/Physician Medicare/Medicaid Crossover

Overview

The Medical/Physician Medicare/Medicaid Crossover claim form was implemented in January 2001. This claim form is an option for the provider community in lieu of the traditional CMS-1500 claim form, when billing crossover claims. This crossover claim form was designed to give providers a more efficient way to submit crossover claims for payment. Providers can indicate Medicare payment information on the crossover claim form. All necessary information is submitted on one claim form and the Data Entry staff does not have to key from two separate documents. The following are data entry procedures for claims submitted on the Medical/Physician Medicare/Medicaid Crossover Claim Form. The instructions describe and reference each field number on the claim form.

Claim Header – Screen 1

ICN

The operator must verify the ICN number typed on the previous screen by typing the microfilmed ICN stamped on the claim. If an error message appears indicating a difference in the ICN keyed on each screen, the operator must arrow back to the previous screens, locate the error, and correct.

Billing Provider Number (Field 1a)

This field indicates the unique 10-digit number assigned to the physician rendering service. This field requires nine numeric characters. This number always begins with 100 or 200. If the field is left blank, an invalid number is typed or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Location Code (Field 1b)

This field indicates the location of the service rendered. This field requires one alpha character. If the field is left blank, an invalid letter

is typed or a letter is flagged invalid after typing, the claim must be voided and returned to the provider.

Patient's Last Name (Field 2a)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

Patient's First Name (Field 2b)

This field represents the first name of the member. If a first name is not indicated on the claim, leave the field blank and force through the system. Type the first letter of the first name as indicated on the claim form.

RID Number (Field 3)

This field represents the member identification number assigned to the individual seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid, or flagged invalid after typing, type as submitted and force the claim through the system.

Diagnosis Codes (Field 4)

This field represents diagnosis codes for treatment provided to the member. Up to four codes can be typed in. If a code is marked invalid type as written and force through the system. If there is not a code indicated, leave blank and force through the system.

Claim Detail – Screen 2

Total Charge (Field 5a)

This field represents the total of all charges submitted. Type charges as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Total Prior Payments (Field 5b)

This field represents all prior payment, including total Medicare and TPL payments. Type amounts as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is not an amount indicated on the claim form, leave the field blank.

Net Charge (5c)

This field represents the total charges, less any amount due from other insurance carriers. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. The net charge is systematically balanced in Indiana*AIM*. If the system indicates the net charge is out of balance verify that the total charge and TPL amounts have been typed correctly. If the amounts are correct and the net charge remains out of balance, type the amount indicated and force the claim through the system.

From Date of Service (Field 6a)

Type the From Date of Service as indicated on the claim form. If the date is greater than one year, type the date as indicated on the claim form and force the claim through the system.

Through Date of Service (Field 6b)

Type the Through Date of Service as indicated on the claim form. If the Through Date of Service is the same as the From Date of Service, press **Enter** and the field systematically populates. If there is not a Through Date of Service, press **Enter** and the field systematically populates the From Date of Service.

Place of Service (POS) (Field 7)

This field represents the location where service was rendered. Type the place of service as indicated on the claim form. If the information is invalid or the field is blank, type the information as submitted and force the claim through the system. This is a two-digit field. If the information indicated on the claim form is a one-digit number, key a zero before the number.

Procedure Code (Field 8)

The procedure code identifies the services rendered to the Medicaid member. Type the procedure code as indicated on the claim form. If the information is invalid or the field is blank, type the information as submitted and force the claim through the system.

Modifiers (Field 9)

There can be up to three modifiers indicated in this field to allow greater flexibility in billing for services rendered. Type modifiers as indicated on the claim form.

Detail Charge (Field 10)

This field represents charges for services rendered. Type the charge as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500. If there is a $0.00 charge with a valid procedure code type the detail as submitted.

Units (Field 11)

This field indicates the number of units the provider is billing to Medicaid. Type the units as submitted on the claim form. This field requires verification; therefore type the number of units twice.

> *Note: When typing units do not use zeroes or fractions. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Rendering Physician's Number (Field 17)

This field represents the physician who provided treatment. Type the provider number indicated on the claim form. If a provider number is not indicated, leave the field blank.

> *Note: After all details have been completed, press the **Exit Scroll** or **F16** key to exit. If the charges balance, proceed to Screen 3. If the charges are out of balance, check for typing errors and correct or force the claim through the system. You must press the **Exit Scroll** or **F16** key to exit after all details have been typed. If the Enter key is pressed in error or information is typed in error, it must be deleted before the user can exit the screen. Leaving a blank detail line generates a Claims Correction Form (CCF) that is sent to the provider.*

Claim Trailer – Screen 3

Patient's Account Number (Field 23)

This field represents an account number assigned to the member. Type the number indicated on the claim form. If there is not an account number provided, leave the field blank.

Signature (Field 24)

If the provider has signed the claim form, this field populates with the default code **Y**, or yes by pressing **Enter**. If the provider has not signed the claim form, type **N**, for no.

Bill Date (Field 25)

Type the billing date that appears next to the signature. If there is not a date indicated, this field systematically populates with the date of the ICN by pressing **Enter**. If the date is over one year, type the date indicated and force the claim through the system.

Medicare Information – Screen 4

Allowed Amount (Field 18)

This field indicates the total amount allowed by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Deductible Amount (Field 19)

This field indicates the total deductible amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Co-Insurance Amount (Field 20)

This field indicates the total co-insurance amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Amount Paid to Provider (Field 21)

This amount indicates the total payment amount from Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

L/PR122 Amount (Field 22)

This amount indicates the psyche amount. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

TPL Amount

This amount indicates the payment made by another insurance carrier or third party payer other than Medicare or Medicaid. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Criteria for Voiding Medical/Physician Medicare Crossover Claims

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any crossover claims. Crossover claims, from a provider not defined as an exception, cannot be processed and must be voided if missing any of the information listed below:

- Provider number missing or invalid
- Location code is missing or invalid
- Detail contains more than six lines

Section 18: Institutional Medicare/Medicaid Crossover for Outpatient/Home Health

Overview

The Institutional Medicare/Medicaid Crossover claim form was implemented in January 2001. This claim form is an option for the provider community in lieu of the traditional UB-92 claim form, when billing crossover claims. The crossover claim form was designed to give providers a more effective way to submit crossover claims for payment. Providers can indicate Medicare payment information on the crossover claim form; therefore, the Data Entry staff does not have to key from two separate documents. All necessary information is submitted on the claim form. The following are data entry procedures for claims submitted on the Institutional Medicare/Medicaid Crossover Claim Form. The instructions describe each field and reference each field number on the claim form.

Claim Header – Screen 1

Patient Control No. (Field 1)

This field represents the identification number assigned to the member by the outpatient facility. Type the information as submitted on the claim form. If a patient account number is not indicated on the claim form, leave the field blank.

Type of Bill (Field 2)

This field represents the type of bill being submitted by the outpatient facility. Type the information as submitted on the claim form. A TOB is required and it must be valid. If the TOB is flagged invalid after it is typed, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

Statement Covers Period – From Date (Field 3a)

This field represents the beginning date of service provided to the member. Type the date as indicated on the claim form. If the date is

more than one year old, or there is not a date provided, type as submitted and force the claim through the system.

Statement Covers Period – Through Date (Field 3b)

This field represents the ending date of service provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service, the system automatically populates when **Enter** is pressed. If there is not a From Date of Service, the system automatically skips to the next field. If there is not a From Date of Service, but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Claim Detail – Screen 2

REV 001 – Total Charge (Field 4)

This field represents the total charge of all detail lines. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

REV Code (Field 7)

This field represents the specific accommodation, ancillary service, or billing calculation. Type the information as indicated on the claim form. If information is missing, invalid, or flagged invalid after it is typed, correct any typing errors. If information is typed correctly and the code remains flagged invalid, force the claim through the system.

HCPCS (Field 8)

This field represents the common procedure code or HCPCS code for the treatment or service provided to the member. Type the information as indicated on the claim form. If there is not a code indicated, leave the field blank. If the code indicated is invalid or flagged invalid after it is typed, correct any typing errors. If the code has been typed correctly and the code remains flagged invalid, force the claim through the system. Do not type rates or numbers with decimals in this field.

Service Date (Field 10)

This field represents the date service or treatment was provided to the member. Type the date as submitted on the claim form. If the date is missing, leave the field blank. If the date is more than one year old, type the date as submitted and force through the system.

Total Charges (Field 12)

This field represents the total charge for all service units. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Claim Trailer – Screen 3

Prior Payment – Medicare (Payer A) (Field 13b)

This field represents the amount that has been paid by Medicare for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Prior Payment – TPL (Payer B) (Field 14b)

This field indicates the amount paid by any other secondary carrier for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Medicaid Billing Provider Number (Field 15a)

This field indicates the unique 10-digit number assigned to the physician rendering service. This field requires nine numeric characters. This number always begins with 100 or 200. If the field is left blank, an invalid number is typed, or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Location Code (Field 15b)

This field indicates the location of the service rendered. This field requires one alpha character. If the field is left blank, an invalid letter

is typed or a letter is flagged invalid after typing, the claim must be voided and RTP.

Prior Payment (Field 15c)

This field indicates a prior payment made by Medicaid for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Estimate Amount Due (Field 15d)

This field represents the amount due (balance remaining) based on the HCPCS code used and the units of service. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Patient's Last Name (Field 16a)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force the claim through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

First Name (Field 16b)

This field represents the first name of the member. If a first name is not indicated on the claim, leave the field blank and force through the system. Type the first letter of the first name as indicated on the claim form.

RID Number (Field 16c)

This field represents the member identification number assigned to the individual seeking treatment. Type the number as submitted on the claim form. If this number is missing, invalid, or flagged invalid after typing, type as submitted and force the claim through the system.

Principal Diagnosis Code (Field 17)

This field represents the primary reason the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated leave the field blank. If the code is invalid or flagged invalid after it is typed, type the code as submitted and force the claim through the system.

Signature (Field 18)

This field indicates whether the provider has signed the claim form and requires Y for yes, or N for no. The signature line is located at the bottom left hand of the claim form. If the provider signed the claim form, the field populates with the default code Y for yes when **Enter** is pressed. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 19)

This field indicates the date the provider submitted the claim and is located at the bottom left hand of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Medicare Information – Screen 4

Deductible Amount (Field 20a)

This field indicates the total deductible amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Co-Insurance Amount (Field 20b)

This field indicates the total co-insurance amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Blood Deductible Amount (Field 20c)

This field indicates the total blood deductible amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal

points in fields containing dollar amounts, 145.00 must be typed as 14500.

Criteria for Voiding Outpatient/Home Health Crossovers

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any outpatient crossover claims. In addition, the following criteria must be met before a crossover claim is processed:

- Provider number is missing or invalid
- Location code is missing or invalid
- Detail contains more than 45 lines
- Type of bill missing or invalid

Section 19: Institutional Medicare/Medicaid Crossover for Inpatient/Long Term Care

Overview

The Institutional Medicare/Medicaid Crossover claim form was implemented in January 2001. This claim form is an option for the provider community in lieu of the traditional UB-92 claim form, when billing crossover claims. This crossover claim form was designed to give providers a more effective way to submit their crossover claims for payment. Providers indicate the Medicare payment information on the crossover claim form; therefore, the Data Entry staff does not have to key from two separate documents. All necessary information is submitted on the claim form. The following are data entry procedures for claims submitted on the Institutional Medicare/Medicaid Crossover Claim Form. The instructions describe each field and reference each field number on the claim form.

Claim Header – Screen 1

Patient Control No. (Field 1)

This field represents the account number assigned to the member by the inpatient facility. Type the information as submitted on the claim form. If there is not a patient account number indicated on the claim form, leave the field blank.

Type of Bill (Field 2)

This field represents the type of bill (TOB) being submitted by the inpatient facility. Type the information as submitted on the claim form. A TOB is required and must be valid. If flagged invalid after typing, check for typing errors. If there are no errors and the TOB is still flagged as invalid, the claim cannot be processed and must be voided.

Statement Covers Period – From Date (Field 3a)

This field represents the beginning date of service provided to the member. Type the date indicated on the claim form. If the date is more

than one year old, or there is not a date provided, type as submitted and force the claim through the system.

Statement Covers Period – Through Date (Field 3b)

This field represents the ending date of service that was provided to the member. Type the date as indicated on the claim form. If the To Date of Service is the same as the From Date of Service the system automatically populates when **Enter** is pressed. If there is not a From Date of Service, the system automatically skips to the next field. If there was not a From Date of Service, but there is a To Date of Service, go back to the From Date of Service and type the To Date of Service indicated in this field. If the date is more than one year old, type as submitted and force the claim through the system.

Claim Detail – Screen 2

REV 001 – Total Charge (Field 4)

This field represents the total charge of all detail lines. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Detail Line

Base REV Code (Field 5)

This field indicates the base revenue code of the service provided. Type the information as indicated on the claim form. If missing, invalid, or flagged invalid after typing, correct any typing errors. If information has been typed correctly and the code remains flagged invalid, force the claim through the system.

Units (Field 6)

This field represents the number of service units billed in relation to the HCPCS code indicated on the claim form. Type the number of units indicated. If the field is blank, press **Enter** twice and the field populates with the default code of one. This field requires verification therefore the units must be typed twice.

> *Note: When typing units do not use fractions or zeroes. If a fraction is indicated, round to the nearest whole number. For example, 1.5 must be typed as 2 and 1.4 must be typed as 1.*

Claim Trailer – Screen 3

Prior Payment – Medicare (Payer A) (Field 13b)

This field represents the amount that has been paid by Medicare for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Prior Payment – TPL (Payer B) (Field 14b)

This field indicates the amount paid by any other secondary carrier for the member. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Medicaid Billing Provider Number (Field 15a)

This field indicates the unique 10-digit number assigned to the physician rendering service. This field requires nine numeric characters. This number always begins with 100 or 200. If the field is left blank, an invalid number is typed or a number is flagged invalid after typing, the claim must be voided and RTP. This field requires verification; therefore type the number twice.

Location Code (Field 15b)

This field indicates the location of the service rendered. This field requires one alpha character. If the field is left blank, an invalid letter is typed or a letter is flagged invalid after typing, the claim must be voided and RTP.

Prior Payment (Field 15c)

This field indicates a prior payment made by Medicaid for the member. Type the amount as indicated on the claim form. Do not

type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Estimate Amount Due (Field 15d)

This field represents the amount due (balance remaining) based on the HCPCS code used and the units of service. Type the information as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Patient's Last Name (Field 16a)

This field represents the last name of the member. Type the first three letters of the last name as indicated on the claim form, including special characters. If there is not a last name indicated on the claim, leave the field blank and force the claim through the system. The following examples represent the method for typing certain last names:

- St. John must be typed as St.
- Mc Williams must be typed as Mc(space)
- O'Hara must be typed as O'H
- AL-Ismaeli must be typed as AL-

First Name (Field 16b)

This field represents the first name of the member. If a first name is not indicated on the claim, leave the field blank and force through the system. Type the first letter of the first name as indicated on the claim form.

RID Number (Field 16c)

This field represents the member identification number assigned to the individual seeking treatment. Type the number as submitted on the claim form. If the number is missing, invalid, or flagged invalid after typing, type as submitted and force the claim through the system.

Principal Diagnosis Code (Field 17)

This field represents the primary reason the member is receiving services or treatment. Type the information as indicated on the claim form. If there is not a code indicated leave the field blank. If the code

is invalid or flagged invalid after typing, type the code as submitted and force the claim through the system.

Signature (Field 18)

This field indicates whether the provider has signed the calim form. This field requires Y for yes, or N for no. The signature line is located at the bottom left side of the claim form. If the claim was signed by the provider the field populates with the default code Y for yes when **Enter** is pressed. If the provider has not signed the claim form, type **N** for no.

Bill Date (Field 19)

This field indicates the date the provider submitted the claim and is located at the bottom left side of the claim form next to the signature line. Type the date indicated on the claim form. If a date is not indicated on the claim form, this field populates with the ICN by pressing **Enter**. If the date is more than one year old, type the date as submitted and force the claim through the system.

Medicare Information – Screen 4

Deductible Amount (Field 20a)

This field indicates the total deductible amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Co-Insurance Amount (Field 20b)

This field indicates the total co-insurance amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Blood Deductible Amount (Field 20c)

This field indicates the total blood deductible amount by Medicare. Type the amount as indicated on the claim form. Do not type decimal points in fields containing dollar amounts, 145.00 must be typed as 14500.

Criteria for Voiding Inpatient and Long Term Care Crossovers

Please refer to crossover preparation guidelines for providers who are exceptions to the following rules before voiding any outpatient crossover claims. In addition, the following criteria must be met before a crossover claim is processed:

- Provider number missing or invalid
- Location code missing or invalid
- Type of bill missing or invalid

Section 20: Reports

Overview

Reports are systematically generated to monitor entry of claims into Indiana*AIM*. The reports are identified and described in this section.

Data Entry Reports

There are three primary reports that are generated by the Data Entry System. These reports are:

- Transmit Statistics – This report is generated each time the batch conversion program is run to convert claims and prepare them for transfer to the claim engine. It itemizes the batch converted, number of claims in the batch, and number of voided claims.
- End of Day Transmit Statistics – This report is identical to the Transmit Report; however, it reports the cumulative daily total of all batches converted. This report is used for claim balancing.
- Operator Statistics – This report provides productivity information for each user defined in the Data Entry System.
- DS1 Listing – This report provides a list of batches that are in the system, but need further research before being transferred to the claim engine.

The following are examples of the report layouts. The first reports illustrate the results of two claim conversions from the Data Entry System to Indiana*AIM*. The third report contains the daily total of all claims converted from the Data Entry System to Indiana*AIM*.

Transmit Statistics

End-of-Day yy/mm/dd

Production Transmit Statistics

A-XOVER	COUNT	VOID
avxxxxxx	xxx	xxx
avxxxxxx	xxx	xxx
avxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

B-XOVER	COUNT	VOID
bvxxxxxx	xxx	xxx
bvxxxxxx	xxx	xxx
bvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

C-XOVER	COUNT	VOID
cvxxxxxx	xxx	xxx
cvxxxxxx	xxx	xxx
cvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

DENT	COUNT	VOID
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

DENT	COUNT	VOID
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

(Continued)

HH	COUNT	VOID
hvxxxxxx	xxx	xxx
hvxxxxxx	xxx	xxx
hvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

IP	COUNT	VOID
ivxxxxxx	xxx	xxx
ivxxxxxx	xxx	xxx
ivxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

LTC	COUNT	VOID
lvxxxxxx	xxx	xxx
lvxxxxxx	xxx	xxx
lvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

CMSC	COUNT	VOID
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

CMS	COUNT	VOID
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

OP	COUNT	VOID
ovxxxxxx	xxx	xxx
ovxxxxxx	xxx	xxx
ovxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

(Continued)

PHAR	COUNT	VOID

pvxxxxxx	xxx	xxx
pvxxxxxx	xxx	xxx
pvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

COMP	COUNT	VOID
qvxxxxxx	xxx	xxx
qvxxxxxx	xxx	xxx
qvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

Total Claims: xxx Voids: xxx Batches: xxx

End-of Day Transmit Statistics

End-of-Day yy/mm/dd

Production Transmit Statistics

A-XOVER	COUNT	VOID
avxxxxxx	xxx	xxx
avxxxxxx	xxx	xxx
avxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

B-XOVER	COUNT	VOID
bvxxxxxx	xxx	xxx
bvxxxxxx	xxx	xxx
bvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

C-XOVER	COUNT	VOID
cvxxxxxx	xxx	xxx
cvxxxxxx	xxx	xxx
cvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

DENT	COUNT	VOID
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

DENT	COUNT	VOID
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx
dvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

(Continued)

HH	COUNT	VOID
hvxxxxxx	xxx	xxx
hvxxxxxx	xxx	xxx
hvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

IP	COUNT	VOID
ivxxxxxx	xxx	xxx
ivxxxxxx	xxx	xxx
ivxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

LTC	COUNT	VOID
lvxxxxxx	xxx	xxx
lvxxxxxx	xxx	xxx
lvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

CMS	COUNT	VOID
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

CMS	COUNT	VOID
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx
mvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

OP	COUNT	VOID
ovxxxxxx	xxx	xxx
ovxxxxxx	xxx	xxx
ovxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

(Continued)

PHAR	COUNT	VOID
pvxxxxxx	xxx	xxx
pvxxxxxx	xxx	xxx
pvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

COMP	COUNT	VOID
qvxxxxxx	xxx	xxx
qvxxxxxx	xxx	xxx
qvxxxxxx	xxx	xxx

Subtotal Claims: xxx Voids: xxx Batches: xxx

Total Claims: xxx Voids: xxx Batches: xxx

Operator Statistics

DATE 09/29/1998 DAILY OPERATOR PRODUCTION LOG

Operator ID	Claim Type	Batch Number	Total Claims	Total Time
xxxx	xxxxxxx	xxxxxx	xxx	x:xx:xx
	xxxx	xxxxxx	xxx	x:xx:xx

Total Claims Keyed xxx

Total Machine Time xx:xx:xx

DSI Listing

DS1 Listing

-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1
-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1
-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1
-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1
-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1
-xx-xx----	1	xxxxxx	xxxxxxx	xxxxx	xxx	xx	xx:xx	xxxxxxxx.ds1

Glossary

This glossary defines the universal terms of the Indiana Title XIX program as presented in the Request for Proposals (RFP). The spelling and capitalization is approved by the Office of Medicaid Policy and Planning (OMPP) for use in all documents. Any changes made to the original RFP glossary were made at the request of the OMPP. The terms and definitions in the Indiana Title XIX Common Glossary cannot be changed without contacting the Publications Manager of the Documentation Management Unit who obtains confirmation and approval from the OMPP. Individual units should include additional terms, as required, in the glossary of their documents.

590 Program	A state of Indiana medical assistance program for institutionalized persons under the jurisdiction of the Department of Corrections, Division of Mental Health, and Department of Health.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
AVR	Automated voice-response system used by providers to verify member eligibility by phone.
AWP	Average wholesale price used for drug pricing.
auto assignment	Indiana*AIM* process that automatically assigns a managed care member to a managed care provider if the member does not select a provider within a specified time frame.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS about persons receiving Medicaid benefits from the Social Security Administration.
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance members, enrolling them in Medicare Part A or Part B or both programs.

CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CMS	Center for Medicare and Medicaid Services, formerly HCFA
claim	A provider's request for reimbursement of Medicaid-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
core contractor	The successful bidder on *Service Package #1: Claims Processing and Related Services*.
core services	Refers to *Service Package #1: Claims Processing and Related Services*.
county office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for Medicaid using the Indiana Client Eligibility System (ICES).
covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible Medicaid members.

CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
CSHCS	Children's Special Health Care Services. A State-funded program providing assistance to children with chronic health problems. CSHCS members do not have to be Medicaid-eligible. If they are also eligible for Medicaid, children can be enrolled in both programs.
CSR	Change system request.
customer	Individuals or entities that receive services or interact with the contractor supporting the Medicaid program, including State staff, members, and Medicaid providers (managed care PMPs, managed care organizations, and waiver providers).
designee	A duly authorized representative of a person holding a superior position.
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the Health Care Financing Administration.
DME	Durable medical equipment. Examples: wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DPOC	Data Processing Oversight Commission. Indiana state agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.

EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See ***ECC, ECS***.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's remittance advice.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to members. The EOMB details the payment or denial of claims submitted by providers for services provided to members.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's remittance advice (RA).
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible members under the age of 21 offering free preventive health care services, such as: screenings, well-child visits, and immunizations. If medical problems are discovered, the member is referred for further treatment.
EVS	Eligibility Verification System. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice response system.
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.

FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
FIPS	Federal information processing standards.
fiscal year - Indiana	July 1 - June 30.
fiscal year - federal	October 1 - September 30.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged members to allow them to live in the community and avoid being placed in an institution.
HCFA	Health Care Financing Administration, now called Center for Medicare and Medicaid Services (CMS). The federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs.
HCFA-1500	HCFA-approved standardized claim form used to bill professional services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	HCFA Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
HealthWatch	Indiana’s preventive care program for Medicaid members under 21 years of age. Also known as EPSDT.
HIC	Health insurance carrier number.
HIO	Health insuring organization.
HMO	Health maintenance organization.

Hoosier Healthwise	Indiana Medicaid managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), Risk-Based Managed Care (RBMC), and Managed Care for Persons with Disabilities (MCPD).
HRI	Health-related items.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IMD	Institutions for mental disease.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
ISMA	Indiana State Medical Association.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
LAN	Local area network.

LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
lock-in	Restriction of a member to particular providers, determined as necessary by the State.
LTC	Long-term care. Used to describe facilities that supply long-term residential care to members.
MAC	Maximum allowable charge for drugs as specified by the federal government.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCO	Managed care organization.
MCPD	Managed Care for Persons with Disabilities is one of three delivery systems in the Hoosier Healthwise managed care program. In MCPD, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the Indiana Medicaid definition.
MEQC	Medicaid eligibility quality control.
MMIS	Medicaid Management Information System. Indiana's current MMIS is referred to as Indiana*AIM*.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to on-line, real-time eligibility information.
non-core services	Refers to *Service Packages #2 and #3*.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
NPIN	National provider identification number.
OMNI	A point-of-sale device used by providers to scan member ID cards to determine eligibility.
OMPP	Office of Medicaid Policy and Planning.
PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Members are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the member and providing all primary care and authorizing specialty care for the member—24 hours a day, seven days a week.
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid members assigned to the PMP's care.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization.
PRO	Peer review organization.

Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities necessary to meet all federal Pro-DUR requirements and all DUR requirements.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF members, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
RFI	Request for Information.
RFP	Request for Proposals.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
shadow claims	Reports of individual patient encounters with a managed care organization's (MCO's) health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail about procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.

SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
specialty vendors	Provide support to Medicaid business functions but the vendors are not currently Medicaid fiscal agents.
State	Spelled as shown, State refers to the State of Indiana and any of its departments or agencies.
subcontractor	Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

SUR	Surveillance and Utilization Review. Refers to system functions and activities mandated by the Center for Medicare and Medicaid Services (CMS) that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements: • statistical analysis • exception processing • provider and member profiles • retrospective detection of claims processing edit/audit failures/errors • retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards • retrospective detection of fraud and abuse by providers or members • sophisticated data and claim analysis including sampling and reporting • general access and processing features • general reports and output
systems analyst/engineer	Responsible for performing the following activities: • Detailed system/program design • System/program development • Maintenance and modification analysis/resolution • User needs analysis • User training support • Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TPL	Third Party Liability.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services*.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.

UCC	Usual and customary charge.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
VFC	Vaccines for Children program.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years of age.

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